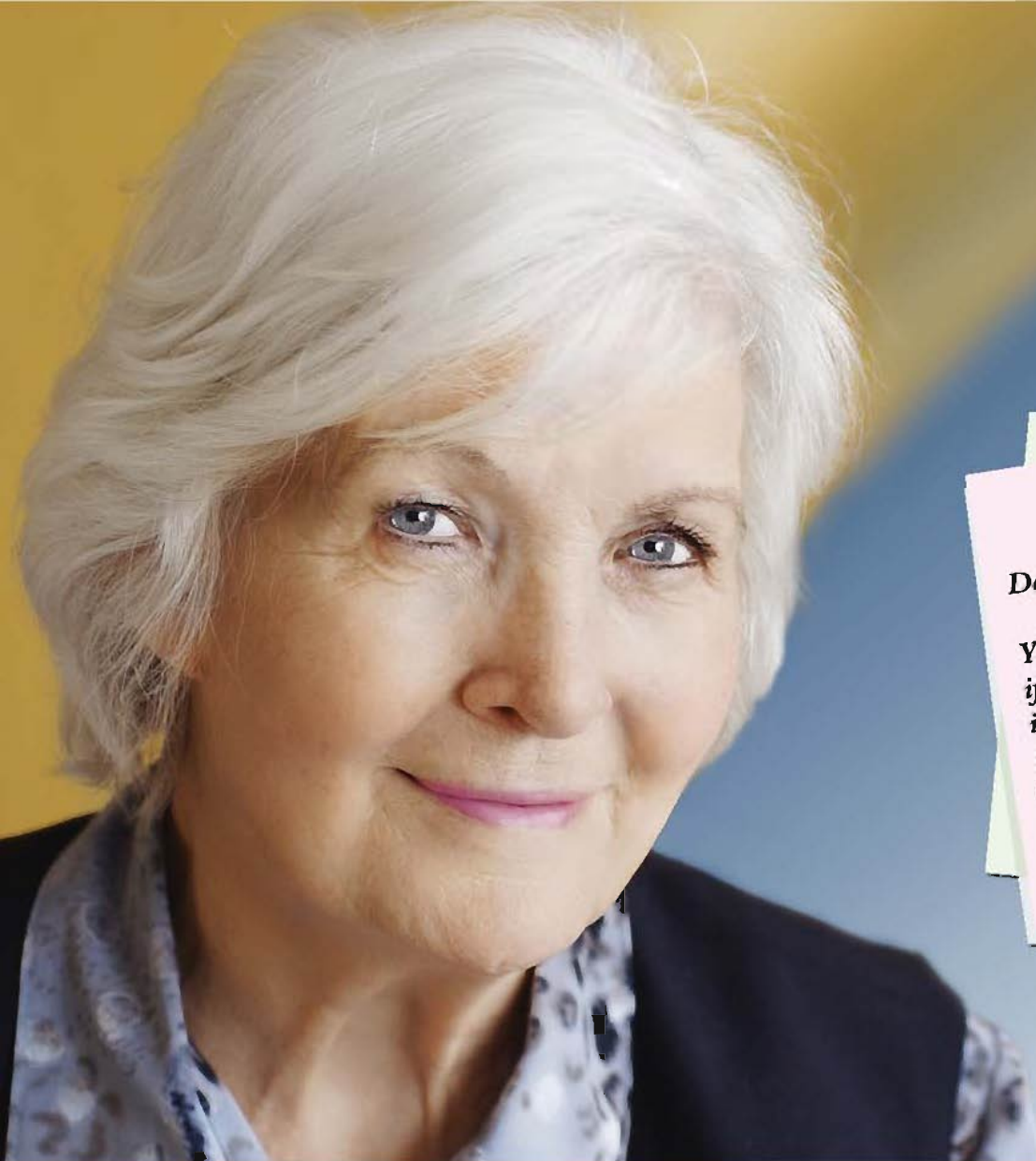




ARIZONA STATE RETIREMENT SYSTEM

2009 Retiree Group Insurance OPEN ENROLLMENT GUIDE

(Effective January 1, 2009)



Dear Retiree:

You do **NOT** need to take any action if you are already enrolled in ASRS insurance & you want your coverage to carry over to 2009. Your coverage will automatically carry forward. You are still encouraged to review this guide for changes & updates.

Arizona State Retirement System

Open Enrollment

2009



ARIZONA STATE RETIREMENT SYSTEM

3300 North Central Avenue • PO Box 33910 • Phoenix, AZ 85067-3910 • Phone (602) 240-2000
7660 East Broadway Boulevard • Suite 108 • Tucson, AZ 85710-3776 • Phone (520) 239-3100
Toll Free Outside Metro Phoenix and Tucson 1-800-621-3778

Dear Retired Member:

This open enrollment guide is intended to assist retired members of the Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan, Elected Officials' Retirement Plan, and the University Optional Retirement Plans in making informed decisions about participating in the ASRS retiree health care program.

We have been fortunate in the administration of our retiree health insurance program to have had, for the most part, consistent and stable plan designs, benefit levels and premiums. We are very pleased to inform you that this coming year there will be no increase in premiums for any of our plans, medical or dental. Also, all of our enrolled retirees will not see changes in plan provisions. As such, if you are satisfied with you current health insurance elections, there is no need to complete any paperwork. If you are currently enrolled with ASRS, your election will automatically carry forward to 2009.

The information contained in this brochure explains, in summary fashion, the benefits of enrolling in the ASRS retiree health care program. The ASRS program includes choices of medical and dental plans, a prescription discount drug card applicable to all retirees whether or not enrolled in the ASRS program, and the SilverSneakers fitness program. There are other useful and important topics covered in this guide, such as premiums for the insurance plans, explanations of the Premium Benefit, an overview of your Medicare benefits, and various worksheets and instructions on how to complete the enrollment process.

This year's open enrollment period will occur from October 20 through November 14, 2008. This open enrollment packet contains all you need to make informed decisions about the medical and/or dental plans in which you may enroll or continue to be enrolled. Your selection(s) will become effective January 1, 2009.

As always, if you have questions about any aspect of your retirement benefits or your retiree health care plans, an ASRS Benefits Advisor in our Member Services Division is available to respond to your questions and concerns. Likewise, assistance may be received from the Public Safety Personnel Retirement System staff if you are a retiree of that retirement system or the Corrections Officer or Elected Officials' retirement plans. Phone numbers and website addresses are listed on the inside back cover of this guide.

Sincerely,

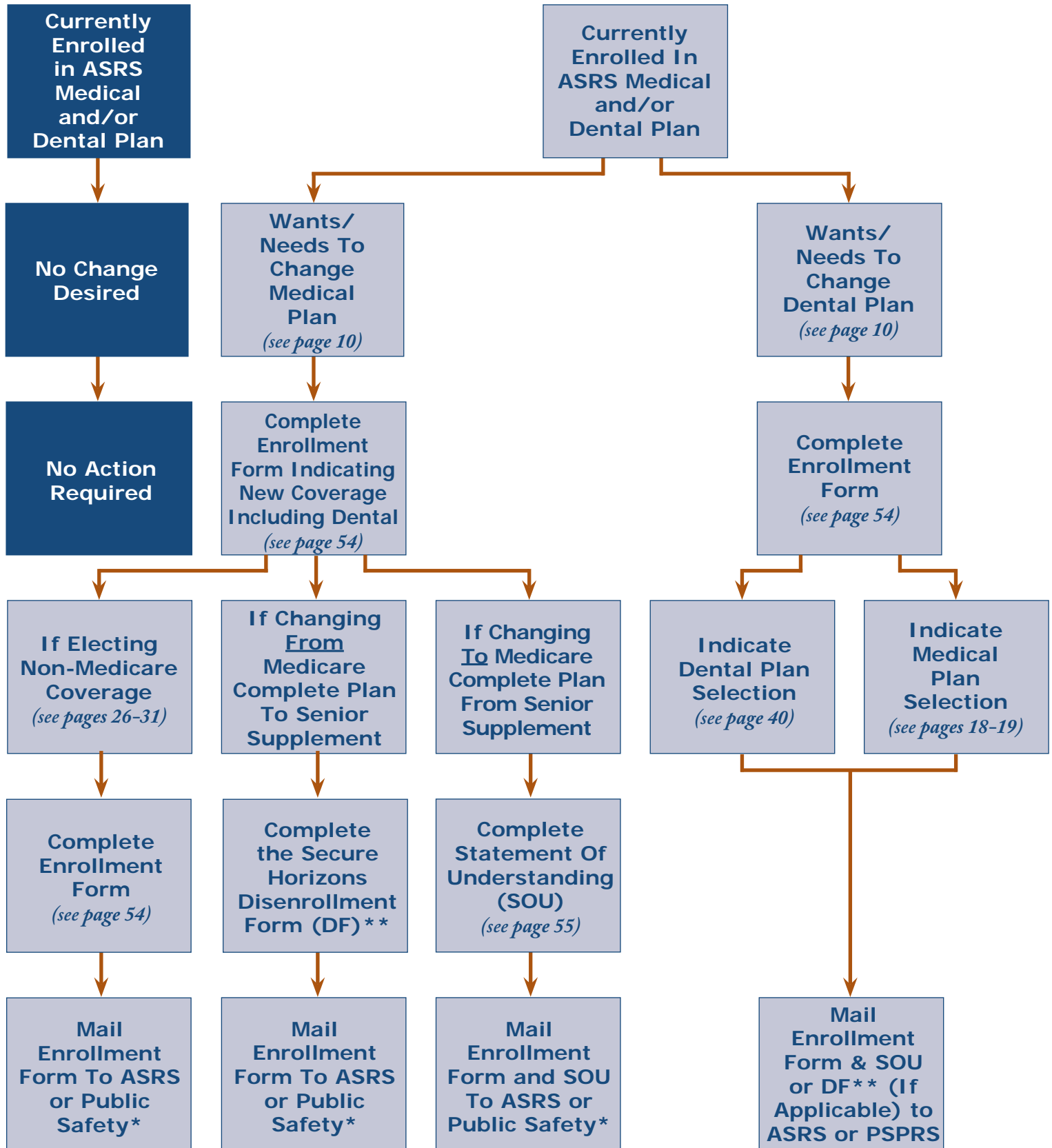
A handwritten signature in black ink, reading "Paul Matson". The signature is stylized, with the first letters of the first and last names being capitalized and prominent.

Paul Matson
Director

Table of Contents

Welcome from the Director	Inside Front Cover
ASRS Enrollment-at-a-Glance	2-3
Open Enrollment Meeting Schedule	4-5
Improvements, Changes and Important Information	6
What's New for Plan Year 2009	7-8
About This Guide	9
Overview of 2009 Retiree Group Health Insurance Program	9-17
ASRS Retiree Medical Plans	18
What Medical Plan Am I Eligible For?	19
Becoming Medicare Eligible	20
MedicareComplete Disenrollment Form	20
Comparison of Benefits	21
2009 Medicare Eligible Retiree Medical Plans Comparison Chart	22-23
Your Medicare Benefits	24-25
2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart	26-31
ASRS Retiree Medical Plans Sample ID Cards	32-33
Understanding the ASRS Medicare Eligible Retiree Prescription Drug Plans	34-35
The Senior Supplement Prescription Drug Plan	36
General Information About PacifiCare's Prescription Drug Benefits	37
PacifiCare's Vision Benefits	38-39
ASRS Retiree Dental Plans	40
Important Things to Consider When Making Your Dental Plan Election	41
Assurant Dental Plans Comparison Chart	42-43
ASRS Retiree Dental Plans Sample ID Cards	44
Assurant Vision Service Plan (VSP) Discount Benefit	45
Additional Benefit Programs	
ScriptSave, Your Prescription Drug Discount Card Program	46
The SilverSneakers Fitness Program	47-49
PacifiCare Wellness and Disease Management Programs	50-51
PacifiCare's Caregiver Program	52-53
Completing Your Enrollment Form & Calculating Your Cost	
How to Complete Your 2009 Enrollment Form	54
Statement of Understanding (SOU)	55
Cost of Coverage: Medical Plan Premiums	56-57
Cost of Coverage: Dental Plan Premiums	58
Calculating Your Monthly Health Insurance Cost	58-59
Retiree Health Insurance Premium Benefit Program	60
Additional Temporary Health Insurance Premium Benefit Amounts (Rural Subsidy)	61-62
Your Pension Check, Health Insurance Premiums & Premium Benefit	63
Copy of ASRS Pension Check	64
Frequently Asked Questions (FAQs)	65-71
Glossary	72-75
Telephone Numbers & Websites	Inside Back Cover

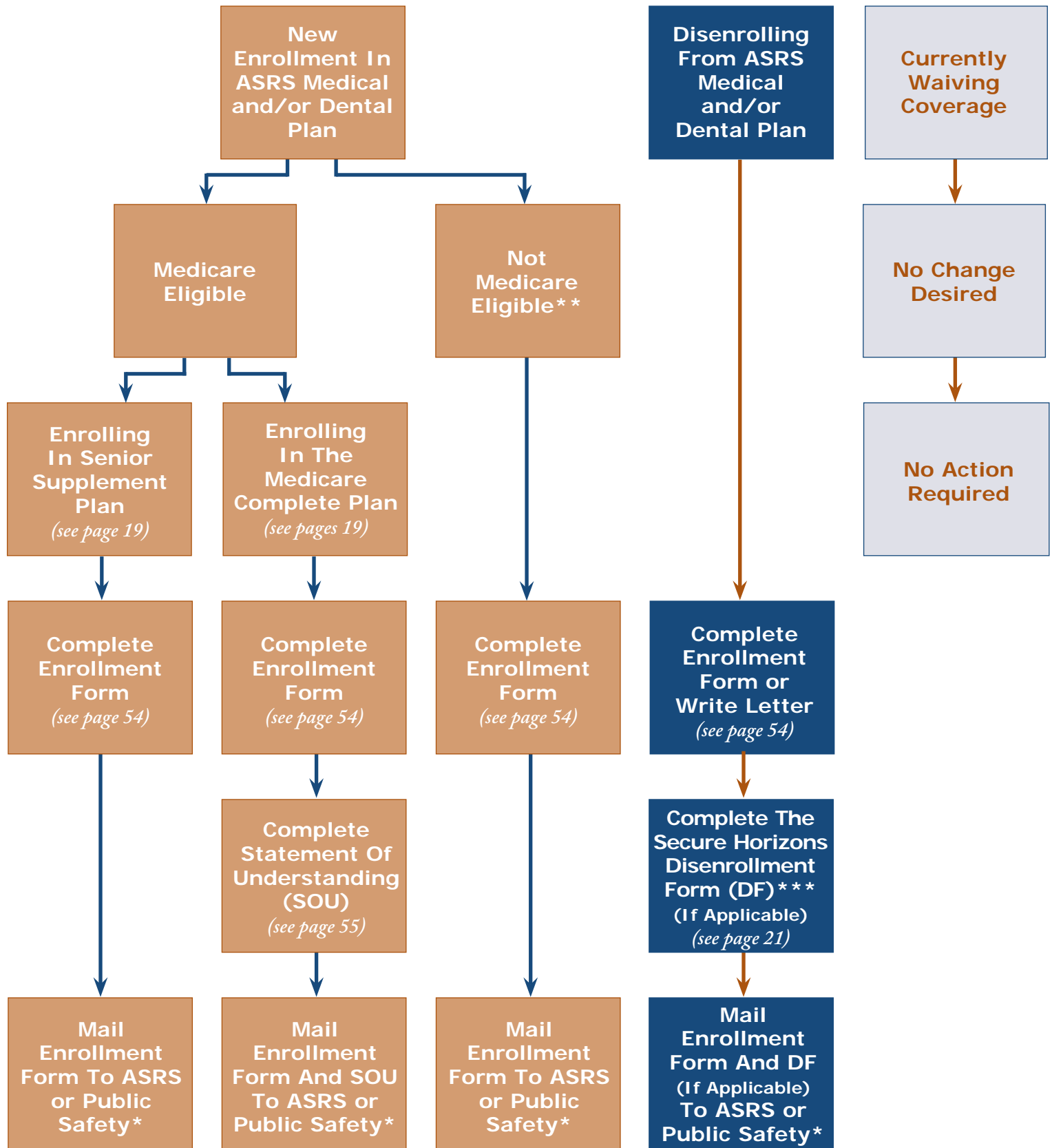
ASRS 2009 OPEN



*Mail enrollment form to Public Safety ONLY if you are a member of PSPRS, CORP, or EORP.

**DF = Disenrollment Form

ENROLLMENT *At-a-Glance*



*Mail enrollment form to Public Safety ONLY if you are a member of PSPRS, CORP, or EORP.

**If enrolling in PPO Plan for the first time, provide a copy of certificate of continuous coverage. See page 71.

*** DF = Disenrollment Form

Retiree Health Insurance Open Enrollment Meetings

October 20-November 14, 2008

No Reservations Required

Presentations have been scheduled throughout Arizona from October 20 to November 14, 2008, with the Arizona State Retirement System (ASRS) Member Services Division and representatives of PacifiCare, Assurant, ScriptSave and the SilverSneakers Fitness Program to discuss their health insurance and benefits programs.

These meetings are an opportunity for members to hear the insurance representatives make formal presentations about their plans.

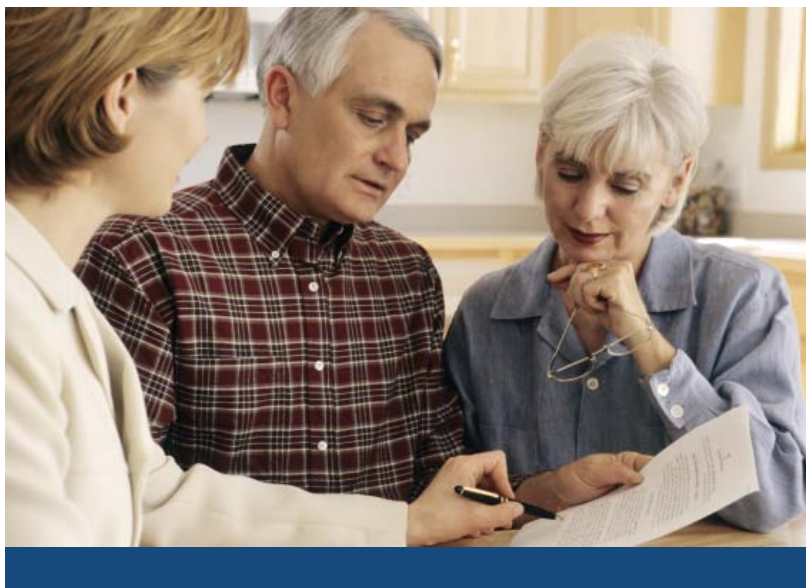
No appointment is necessary. Just come to the meeting day and time that best suits your schedule. Early arrival is always recommended and attending an earlier meeting is encouraged if it is convenient for you to do so.

The meetings will begin at the time designated on the schedule that follows and are approximately two hours in length.

Question and answer sessions will follow each meeting. You are encouraged to ask questions regarding plan differences and applicability so that informed decisions are made concerning your participation in a selected medical and/or dental plan.

Specific, personal medical and/or dental issues should be addressed to PacifiCare or Assurant Customer Service Centers. Their phone numbers are on the inside back cover of this guide.

If you are a PSPRS, CORP or EORP retiree, do not hand in your enrollment form at these meetings. Please mail it to the PSPRS office in the pre-addressed return envelope PSPRS provided in their open enrollment packet.



2009 Open Enrollment Meeting Schedule

PHOENIX	ASRS Boardroom, 3300 N Central Ave 10th Flr	10/20	10 AM & 2 PM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	10/22	10 AM & 2 PM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	10/24	10 AM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	10/30	10 AM & 2 PM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	11/4	10 AM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	11/6	2 PM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	11/12	10 AM & 2 PM
	ASRS Boardroom, 3300 N Central Ave 10th Flr	11/14	2 PM
TUCSON	7660 E Broadway Blvd, Suite #108	10/21	10 AM & 2 PM
	7660 E Broadway Blvd, Suite #108	10/28	10 AM & 2 PM
	7660 E Broadway Blvd, Suite #108	10/30	10 AM & 2 PM
	7660 E Broadway Blvd, Suite #108	11/6	10 AM & 2 PM
	7660 E Broadway Blvd, Suite #108	11/13	10 AM & 2 PM
CASA GRANDE	Gila Council for Seniors, 8969 W McCartney Rd	10/23	10 AM & 2 PM
FLAGSTAFF	Flagstaff High School Mini Auditorium, 400 W Elm	10/28	3 PM
	City Council Chambers, 211 W Aspen Ave	10/29	10 AM & 2 PM
GLENDALE	City of Glendale Council Chambers, 5850 W Glendale Ave*	10/30	10 AM & 2 PM
GLOBE	City of Globe Council Chambers, 150 N Pine St	10/22	2 PM
KINGMAN	Kingman School Dist Board Rm, 3033 McDonald Ave	11/12	2 PM
	Kingman School Dist Board Rm, 3033 McDonald Ave	11/13	9 AM
LAKE HAVASU	Lake Havasu Unified Dist Board Rm, 2200 Havasupai Blvd	11/13	1 PM
MESA	Mesa Public School Board Room, 549 N Stapley Dr**	10/31	10 AM & 2 PM
	Mesa Public School Board Room, 549 N Stapley Dr**	11/3	10 AM & 2 PM
PAYSON	Town Of Payson Council Chambers, 303 N Beeline Hwy	10/27	11 AM
PRESCOTT	Yavapai County Admin-Mackin Bldg, 840 Rodeo Dr	10/27	2 PM
	Yavapai College-Perform Hall (Green Rm), 1100 E Sheldon	10/28	9 AM
SHOW LOW	VFW Hall, 381 N Central	10/21	10 AM
SIERRA VISTA	Sierra Vista Police Dept, 911 N Coronado Dr	10/29	10 AM & 2 PM
SAFFORD	Graham County Complex, 921 Thatcher Blvd	10/22	10 AM & 2 PM
TEMPE	Tempe Elem Dist, Sanchez Bldg Board Rm, 3205 S Rural Rd***	10/24	10 AM & 2 PM
WICKENBURG	Wickenburg Town Hall Council Chambers, 155 N Tegner	11/10	1 PM
YUMA	City Of Yuma, 1 City Plaza, Room 142	11/6	10 AM

**Handicapped may park in garage - all others must park in open lot at 59th Ave & Myrtle.*

***Please Park in the Conference Parking Lot.*

****Please Park in the Fry's Grocery Store Parking Lot.*

Improvements, Changes and Important Information Regarding the 2009 ASRS Retiree Health Care Program

The ASRS is pleased to present the annual 2009 Open Enrollment. This year's Open Enrollment period will be held October 20 through November 14, 2008. You may enroll, change health plans, or add eligible family members not currently enrolled under this program. Any changes made during open enrollment take effect January 1, 2009. This is your once-a-year opportunity to change your current medical or dental coverage if you wish.

You do not need to take any action if you are already enrolled in ASRS insurance and want your coverage to carry over to 2009.

This is not a positive re-enrollment of every member. **Your current ASRS benefit elections will automatically carry forward to 2009, unless you make a change in plan coverage.** No action on the part of a retired member or LTD recipient is required if you: are already enrolled with the ASRS in a medical and/or dental plan and do not wish to make any changes; are not currently enrolled in ASRS coverage and do not wish to enroll in coverage at this time; or, are enrolled in your former employer's health insurance program and do not want to change to the ASRS coverage.

ASRS 2008 premiums and plan provisions will carry forward to 2009. There will be no change in insurance carriers for 2009. Monthly medical and dental plan premiums and plan provisions for ASRS plans will not change.

DEADLINE: If you are enrolling for the first time or making a change, your completed open enrollment forms **MUST** be submitted to ASRS, or PSPRS, if applicable, by **November 14, 2008**.

- Read all Open Enrollment information contained in this guide. Mark your calendar to attend one of the Statewide Health Insurance Open Enrollment Meetings.
- Review the Open Enrollment Frequently Asked Questions (FAQs) section in this guide.
- If you are happy with your current coverage, **NO ACTION IS REQUIRED**.
- If you want or need to make a change, complete the enrollment form and submit by the deadline.

Important Information About Medicare Part D

Effective January 1, 2006, Medicare added a new prescription drug benefit known as Part D. ASRS Medicare eligible members have prescription drug coverage as part of our medical plans that is as good or better than what is available under Part D. So you should not enroll in a separate non-ASRS Part D Plan. Enrollment in a separate non-ASRS Medicare Part D prescription drug plan will require the ASRS and PacifiCare to terminate your ASRS coverage. Medicare does not allow you to be enrolled in two Part D plans at the same time.

What's New for 2009

Definition of Eligible Dependent Expanded

Recently, the state's benefits program was modified to include domestic partners as eligible dependents. Effective January 1, 2009, the ASRS retiree health insurance program will also include coverage for domestic partners. Please see page 16 of this enrollment guide for further details.

Rural Subsidy to end June 30, 2009

Medicare eligible retirees enrolled in the ASRS, Arizona Department of Administration (ADOA), or other employer medical plan and who live in Mohave, Gila, Navajo or Apache Counties have the additional, temporary premium benefit (rural subsidy) to help offset the cost of health insurance premiums. This additional premium benefit is set to end on June 30, 2009.

Effective July 1, 2009, PacifiCare will offer its MedicareComplete (HMO) Plan to Medicare eligible retirees residing in these four counties. ASRS will conduct a "special enrollment" period in May, 2009 during which retirees may elect to participate in the PacifiCare/Secure Horizons MedicareComplete (HMO) Plan at monthly premiums less than the ASRS Senior Supplement plan.

RFP for 2010

PacifiCare has been providing various medical plans to ASRS retired and disabled members since 1989 as either the sole provider or in combination with other carriers. The current contract with PacifiCare began in January 2005 and will end December 31, 2009. State law requires the ASRS to bid for medical insurance services every five years. The ASRS will conduct

a Request for Proposal (RFP) in January 2009 at which time potential bidders will be asked to submit proposals to offer our retired members medical insurance plans. The ASRS will evaluate these proposals and award contract(s) in May 2009 for a January 1, 2010 start date. Future editions of *Your Retirement*, our new retiree newsletter, will keep you informed of the bid process and its award.

Retiree Insurance Cards will not change

You will continue to use your current medical plan ID card in 2009. ID cards will only be provided to newly enrolled members and members changing medical plans.

PacifiCare to add the "tier" concept to prescription drugs for Medicare eligible retirees

PacifiCare is reclassifying its prescription drugs as Tier 1, 2, 3 or 4 to match Medicare Part D descriptions. Much of Medicare's communication about its Part D program refers to prescription drugs in "tiers" or in various classifications as noted below. The important thing to remember is that the co-pays for which you are responsible do not change. To avoid the confusion that could arise because Medicare and PacifiCare refer to similar classifications differently, PacifiCare will now use Medicare's prescription drug classification system.

- Tier 1 are preferred generic medications
- Tier 2 are preferred brand name medications
- Tier 3 are non-preferred medications (these require prior authorization on the MedicareComplete HMO plan)
- Tier 4 are specialty medications (these require prior authorization on both ASRS Medicare eligible plans)

What's New for 2009

See page 23 for Medicare copayments and page 28-29 for Non-Medicare copayments.

ScriptSave Prescription Drug Savings Card Now Web Based

Members can now obtain a card by going to www.scriptsave.com. Log-in by entering Group # 869 and click "Log-in". Go to the "Card Services" link to enroll and print out a prescription drug savings card. See the ScriptSave Section of this guide for full details.

MedicareComplete HMO changes:

- Routine physicals are now covered at no copay
- Routine hearing exams are now covered at no copay
- Hearing aids now have a \$500 allowance every 3 years

Also, please note page 15 regarding hearing benefits through Arizona Hearcare Network (AHN). AHN provides, at no additional premium, many valuable hearing services.

MEDICARE CHANGES:

Senior Supplement Prescription Drug Plan

The limits for the Senior Supplement prescription drug plan coverage are changing in 2009. The coverage gap, known as the "donut hole," increases from \$2510 to \$2700 and the new TrOOP (true out of pocket) cost increases from \$4050 to \$4350, which is when catastrophic coverage begins. Please see page 34 for detailed information on how the changes will affect you.

About This Guide

Information provided in this guide is intended solely as a reference to help you make important enrollment decisions.

The benefits described are highlights of the Arizona State Retirement System's (ASRS) retiree health insurance program and are effective January 1, 2009 unless otherwise noted.

This guide constitutes a summary of the ASRS' official plan documents, contracts, Arizona statutes and federal regulations that

govern the plans. If there is any discrepancy between the information in this guide and the official documents, the official documents will always govern.

The Arizona State Retirement System reserves the right to change or terminate any of its plans, in whole or in part, at any time.

Published by:

Arizona State Retirement System
External Affairs Division
3300 North Central Avenue
Phoenix, AZ 85012

Overview of 2009 Retiree Group Health Insurance Program

PLEASE READ THIS GUIDE CAREFULLY.

The Arizona State Retirement System (ASRS) will conduct its 2009 retiree group health insurance program open enrollment beginning Monday, October 20, 2008, and concluding Friday, November 14, 2008. Coverage you select will become effective January 1, 2009. **The information in this guide will assist you in making informed decisions about your health insurance coverage for 2009**, as well as prepare you for any **changes in deductions from pension checks or changes in premium amounts** billed to you beginning January 1, 2009.

Are there any changes in the health care plans offered by the ASRS in 2009?

- Premiums for all medical and dental plans will remain unchanged in 2009.
- Plan provisions for all medical and dental plans will remain unchanged in 2009, except for the improvements made in the MedicareComplete HMO plan as noted on page 8.

Who is eligible to participate?

Enrollment applies to any retired member and eligible dependents of the ASRS, Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), University Optional Retirement Plans (UORP), or any member who begins to receive a long-term disability (LTD) benefit from the ASRS program and who may not be enrolled in health insurance benefits through his or her former employer.

If you are currently enrolled for health insurance with your former employer, please contact them for specific employer-related enrollment information and continued eligibility for their insurance coverage.

Who is an 'eligible dependent'?

Your legal spouse,

A domestic partner, which is defined as a legal or personal relationship between two

individuals who live together and share a common domestic life but are neither joined by a traditional marriage nor a civil union (see page 16-17),

Natural or adopted children or stepchildren who reside with you, or are placed by court-order, and under age 19, or under 25 if a full-time student (minimum of 12 credit hours) at an accredited educational institution,

Minors under the age of 19 for whom the employee or legal spouse have court-ordered guardianship,

Foster children under age 18, and

Natural, adopted and/or stepchildren who reside with you or are placed by court order and were determined to be disabled by Social Security Administration (SSA) guidelines.

If you enroll your eligible dependent(s), additional documentation may be requested:

If you have a dependent enrolled in an institution of higher learning (e.g. university, community college, vocational or technical school), you will be requested to provide documentation showing full-time student status. A student is considered full time if the student meets any one of the following three criteria:

- the student is an undergraduate taking at least 12 credits; or,
- the student is a graduate student taking at least 9 credit hours; or,
- the post-secondary school, which does not record class time in credit hours, classifies the student as full-time.

Required documentation is either a letter from the school documenting the student is a full-time student and tuition has been paid in full or a copy of the class schedule with a school "paid in full" stamp or certificate from the school. Balance due statements or class schedules without the school paid in full stamp are not acceptable documentation. Proof is required each semester.

If you have a dependent child approaching age 19 who is disabled or under legal guardianship, you will be requested to provide:

- a certified copy of a court order granting legal guardianship, or
- verification that your dependent child has a qualifying permanent disability that occurred prior to his or her 19th birthday and is in accordance with Social Security Administration guidelines. This continuation of coverage is also subject to approval by the Medical Director of the Medical and/or Dental Health Insurance providers for ASRS.

Who should complete a 2009 Enrollment Form?

You must complete and return your 2009 Enrollment Form if you:

- are electing a different medical plan,
- are electing a different dental plan,
- are adding dependents,
- are dropping coverage (this means you are currently enrolled with ASRS and you wish to cancel your coverage) you may also send a letter in lieu of submitting an enrollment form,
- are a new enrollee with the ASRS,
- become Medicare eligible in January 2009, or
- move your primary residence which would cause a change in health care plan eligibility.

If you fall into one of these categories, and you want medical and/or dental insurance through the ASRS during 2009, you must complete a 2009 Enrollment Form in its entirety and return it by **November 14, 2008**.

Should every eligible member complete an enrollment form?

This is not a positive re-enrollment for most members. No action on the part of a retired member or LTD recipient is required if you:

- **are already enrolled** with the ASRS in a medical and/or dental plan and do not wish to make any changes,
- **are not currently enrolled** for ASRS coverage and do not wish to enroll for coverage at this time, or
- **are enrolled in your former employer's** health insurance program and do not want to change to the ASRS coverage.

What will happen to the ASRS retiree medical plan in which I am enrolled when I become eligible for Medicare?

If you are enrolled in an ASRS medical plan and you become eligible for Medicare, **you will have to enroll in one of the two ASRS medical plans for Medicare eligible retirees.** The ASRS has medical plans for retirees who are not Medicare eligible and plans for retirees who are Medicare eligible.



Your plan change will become effective on the first day of the month in which you become eligible for Medicare (provided ASRS receives all required information prior to the requested effective date). This means that you need to notify the ASRS (or PSPRS, if applicable), **prior** to the month in which you become Medicare eligible. The Centers for Medicare and Medicaid Services (CMS) will mail a Medicare card to you 3 months prior to your eligibility. The Medicare card will include your name, Medicare claim number, the type of coverage you have (Part A, Part B, or both), and the date your Medicare coverage starts. If you are eligible for Medicare, **you must have Part A and Part B to participate in an ASRS Medicare eligible medical plan.**

In addition to completing a new health insurance enrollment form(s), you will need to provide a copy of your Medicare card to the ASRS or PSPRS, if applicable. Please remember that you need to submit your completed paperwork prior to the first of the month in which you become Medicare eligible.

If you elect to enroll in the Medicare-Complete plan, you are also required to submit a Statement of Understanding (SOU). See page 55.

If you have been receiving Social Security Disability Income benefits for two years, you may become eligible to enroll in Medicare. You should complete your Medicare enrollment process well before your eligibility date so that you may transition to an ASRS Medicare eligible medical plan in a timely manner.

I forgot to notify the ASRS or PSPRS, if applicable, that I became Medicare eligible. What will happen to the retiree medical plan in which I am enrolled?

If you fail to notify the ASRS (or PSPRS, if applicable) that you became Medicare eligible, the medical plan in which you are enrolled will continue unchanged until you properly complete the enrollment process. It is very important to note that **the premium benefit to which you are entitled will reduce** to the amount applicable to Medicare eligible retirees. As a result, **you will be paying a larger portion** of your health insurance premium by remaining in your non-Medicare plan. State law governs how much premium benefit is paid for non-Medicare and Medicare eligible retirees. In order to receive the highest premium benefit and pay the lowest health insurance premium, please let the ASRS (or PSPRS, if applicable), know that you are eligible for Medicare **prior** to the month in which you become Medicare eligible.

Your ASRS coverage will always be effective on the first day of the month **following** receipt of your completed ASRS enrollment application. Therefore, **there is no retroactive coverage** for health insurance. Please remember to begin your enrollment process with the ASRS (or PSPRS, if applicable), **before** you become Medicare eligible.

What is the Premium Benefit Program?

This benefit is provided to each eligible retired and disabled member who elects to participate in a health insurance plan sponsored by the ASRS, the Arizona Department of Administration, or a participating employer. This benefit helps reduce monthly health insurance premiums. The benefit to which you are entitled is dependent upon your years of credited service, enrollment in single or family coverage and whether you are Medicare eligible. Please see page 60 for more information.

Are you a retiree or LTD recipient enrolled in a health care plan provided by your employer?

If you are enrolled in a Participating Employer's health care plan and you wish to become enrolled in the ASRS retiree health care program, you must complete a health insurance enrollment form and return it to the ASRS (or PSPRS, if applicable), by close of the open enrollment period (November 14, 2008) to have your ASRS coverage effective on January 1, 2009.

You should be aware when your employer conducts their open enrollment so that your coverage with them does not lapse before your ASRS coverage begins. Also, if you are receiving your employer's health care program because of a COBRA event, you should be aware when that coverage terminates. You have a 31-day grace period upon termination of your employer's

COBRA coverage to enroll in an ASRS health care plan.

If you fail to enroll with the ASRS in a timely manner you will have to wait until the next ASRS open enrollment period to complete a health insurance enrollment form and be eligible for the ASRS retiree health care program.

After I enroll in an ASRS retiree health care plan, when can I expect to receive my ID cards?

PacifiCare will mail your medical plan ID card(s) approximately 10 days prior to the first day of the month in which your medical plan becomes effective. Likewise, Assurant will mail your dental plan ID card(s) approximately 10 days prior to the first day of the month in which your dental plan becomes effective.

This year, medical and dental plan ID cards will only be provided to newly enrolled members and members changing medical or dental plans.

My current coverage is available next year and I do not want to change. What do I need to do?

Your coverage will automatically continue into next year. **It is not necessary to send any form to the ASRS (or, if applicable, PSPRS).**

I wish to cancel my coverage. What do I need to do?

All cancellations must be in writing. You may use the ASRS (or PSPRS, if applicable), enrollment form to decline medical and/or dental coverage or you may send a letter to cancel your coverage. Your written termination request must be received by the ASRS (or PSPRS, if applicable), prior to the first of the month in which you wish to cancel. Written termination requests received after the first of the month will be applied to the first of the following month unless a future date is requested.

If you are enrolled in the Medicare Complete or Senior Supplement plans, you must also submit a disenrollment form to "unlock" your Medicare so you may return to traditional Medicare.

When does the group insurance open enrollment period end?

The open enrollment period for health insurance elections will close Friday, November 14, 2008. This means that if you are making new elections or adding or deleting dependents from your health insurance coverage, your enrollment form must be received by the ASRS or PSPRS or be postmarked no later than midnight, Friday, November 14. You must do this in order for your requested election(s) to be effective on January 1, 2009.

What will happen if I don't submit my enrollment form by November 14, 2008?

If you wish, or are required, to make a plan change and you fail to submit your completed enrollment form by the close date, your election(s) will not become effective.

Consequently, you may lose coverage and will not be eligible to re-enroll in the ASRS retiree health insurance program until the next open enrollment, which will take place in the autumn of 2009. However, should you experience a "qualifying event," as defined by law, during the course of the year, you may enroll in an ASRS retiree medical and/or dental plan at that time.

What is a qualifying event?

A "qualifying event" permits members to make certain mid-year changes to their benefits coverage that are consistent with the qualifying event. If you have a qualifying event and want to enroll or are required to make a change in your coverage, (i.e., add or delete dependents or are required to change

your benefit plan), you must notify the ASRS (or, PSPRS, if applicable), Member Services, in writing, within 31 days of the event to request a change. Following is a list of eligible qualifying events:

- change in member's marital status, i.e. marriage, divorce, legal separation, annulment, death of spouse (i.e., enroll yourself and/or add or delete a spouse),
- change in dependent status, i.e. birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, student status (i.e., enroll yourself and/or add or delete eligible dependents),
- change in member's primary residence causing a change in benefit plan availability (i.e., change medical and/or dental plans),
- eligibility for Medicare, i.e. member, spouse, dependent child (enroll yourself and add your eligible dependents in a medical and/or dental plan or, if enrolled, change medical plan of affected person),
- significant change in spouse's group benefits plan cost or coverage (i.e., enroll yourself if you are enrolled in your spouse's group benefit plan and/or add or delete eligible dependents),
- significant change in Participating Employer's group benefits plan cost or coverage (i.e., enroll yourself and add eligible dependents), and
- termination of COBRA coverage - member, spouse, dependent child (i.e., enroll yourself and/or add eligible dependents).

I am enrolled in an Arizona Department of Administration (ADOA) retiree health care plan. What are my enrollment options with the ASRS?

Study the enrollment materials provided to you by the ADOA and the ASRS (or, PSPRS, if applicable). If, after comparing

the ASRS retiree health care information, you believe that the ASRS may offer you a better value, then make new elections and return your enrollment form by November 14. You will also need to notify the ADOA *in writing* if you would like to discontinue your health insurance benefits with ADOA effective December 31. The ASRS coverage will then become effective January 1. Please keep in mind that once you decide to enroll in ASRS benefits, you may no longer elect ADOA coverage in the future. On the other hand, if you are satisfied with your ADOA coverage, ignore the ASRS (or PSPRS, if applicable), open enrollment packet and follow ADOA open enrollment benefit guidelines.

ADOA's open enrollment period is from October 1-31, 2008. If it is your wish to remain with ADOA coverage, please respond to ADOA by their deadline, Friday, October 31, 2008.

I am Medicare eligible. Do I have vision benefits through my ASRS medical plan?

If you are enrolled in the MedicareComplete Plan:

You have coverage for routine eye exams (also called refractive eye exams) once every 12 months for a \$20 copayment. These exams are only available through the Spectera vision network which includes Wal-Mart, Sam's Club, Nationwide Vision and Eyemasters. For a complete list of providers, go to www.spectera.com.

Your medical plan covers you for **non-routine medically necessary eye exams for the diagnosis and treatment of diseases or medical conditions of the eye** (such as, but not limited to, cataracts, glaucoma, diabetes, detached retina, etc). Again, these services **are covered under your medical benefits and not under your routine vision benefit**. You must use

a contracted optometrist located in your medical plan provider directory and you may self-refer for these exams. Should you need the services of an ophthalmologist, the referral must be given by a contracted optometrist. The copayment for these office visits is \$20 per visit. For assistance in locating a contracted optometrist, you may also call SecureHorizons' Customer Service at 866-622-8055.

In addition to eye exams, you have an allowance of \$130 toward materials (lenses & frames). This materials allowance is only available through the Spectera network, which includes, but is not limited to, Wal-Mart, Sam's Club, Nationwide Vision and Eyemasters. For a complete listing of providers, go to www.spectera.com. See page 38 for more details.

If you are enrolled in the Senior Supplemental Plan:

You have coverage for routine eye exams (also called refractive eye exams) after a \$20 deductible at a Spectera network provider. Eyeglass lenses (single, bifocal and trifocal) are covered in full, and you have a \$130 retail allowance toward frames. In lieu of eyeglasses, there is a \$105 allowance toward contacts. Exams, lenses and frames are covered once every 12 months. You have the option to see any vision provider you wish. However, to maximize your savings use Spectera network providers, such as Wal-Mart, Sam's Club, Nationwide Vision and Eyemasters.

You are also covered for diagnosis and treatment of diseases or medical conditions of the eye (non-routine services) that may require the services of an eye specialist. These services are not covered under your routine vision benefit. If you need the services of a specialist, you can self-refer to any Medicare contracted eye specialist. See page 39 for more details.

I am Medicare eligible. Do I have hearing benefits through my medical plan?

New for 2009, the MedicareComplete Plan covers routine annual hearing exams at no charge and has a \$500 hearing aid allowance every three (3) years.

Also available for Medicare and non-Medicare members is the Arizona Hearcare Network (AHN). AHN is a discount program NOT an insurance benefit. AHN provides, at no additional premium to the participant, the following:

- \$25 copayment for hearing evaluations,
- \$500 discount towards purchase of digital or programmable hearing aid every 12 months,
- \$300 discount towards purchase of standard or conventional hearing aid every 12 months, and
- 20% discount on accessories and repairs.

You must show your PacifiCare ID card to be eligible for these benefits and must use an Arizona Hearcare Network office. AHN locations are detailed on the Web or through the Customer Service Center. See the inside back cover of this guide for AHN's phone number and website.

Must I use the 2009 Enrollment Form?

The 2009 Enrollment Form will be the only enrollment form acceptable to enroll in, or make changes to, health insurance plan coverage. The enrollment form is included in the open enrollment packet along with a pre-addressed return envelope for your convenience.

However, if you are satisfied with your current elections and you wish to make **NO CHANGES**, then no enrollment form is required to be submitted.

Important reminder: If you want or need to make a change, please complete the

enrollment form in its entirety. Even if you are only changing from one medical plan to another medical plan or from one dental plan to another dental plan, fill out the form completely. **Failure to check a plan coverage you want will indicate that you are not enrolling in that coverage.** So, be thorough. If, in fact, you are declining coverage, please check the appropriate box(es). **A properly completed enrollment form must be received by the ASRS or PSPRS, if applicable, or be postmarked no later than midnight, Friday, November 14, 2008.**

Must I notify the ASRS (or PSPRS, if applicable) of an address change?

Yes, all mailings, including pension and LTD benefit plan checks, newsletters, open enrollment and additional insurance information are delivered to the address of record on file with the ASRS (or, if applicable, PSPRS). It is always in your best interest to ensure a correct mailing address.

While it is understood that many retirees and LTD recipients have direct deposit of their benefit checks and others have seasonal or even secondary addresses (such as a PO Box), the address of the primary residence is key to the availability of medical plan options and their costs as well as the forwarding of important periodic information that may be time sensitive.

In short, it is your responsibility to let the ASRS (or PSPRS, if applicable) know in writing when you have an address change.

How can I find out more about my health care choices?

All eligible members are encouraged to access the ASRS (or, if applicable, PSPRS) website, which is full of useful overviews and explanations regarding many topics of interest. The ASRS website may be found at www.azasrs.gov. The PSPRS website may be found at www.psprs.com.

Eligible members can also attend the Open Enrollment meetings as listed on page 5 of this Guide.

Who is an eligible Domestic Partner?

Effective January 1, 2009, health insurance coverage may be extended to an eligible member's domestic partner. The ASRS will now offer medical and dental coverage to same-gender and opposite-gender domestic partners and their eligible dependent children.

To obtain these benefits, your partner must meet the ASRS definition of a domestic partner. A domestic partnership is a legal or personal relationship between two individuals who live together and share a common domestic life but are neither joined by a traditional marriage nor a civil union. Domestic Partners must share, among other criteria, a residence with the retiree and have done so continuously for the past 12 months, not legally married to or separated from anyone else, not a close blood relative, at least 18 years old, and meets certain financial interdependency test (see criteria below).

To add a domestic partner to your coverage you must complete the Qualified Domestic Partner Certification packet. This packet includes the *Qualified Domestic Partner Affidavit, Declaration of Tax Status* and the *Worksheet for Determining Dependent Status*. Before completing the paperwork and submitting it to the ASRS, it is best if you review the eligibility requirements first. Be sure to return the forms (excluding the Worksheet) to ASRS along with a completed enrollment form by November 14, 2008. The domestic partner paperwork will need to be notarized. Any questions regarding the tax implications should be directed to your personal tax consultant or attorney. ASRS staff does not provide tax advice or counsel.

Eligible Domestic Partner

- A. Your domestic partner is subject to the following qualifications:
 - a. Shares the retiree's permanent residence;

- b. Has resided with the retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the retiree indefinitely as evidenced by an affidavit filed at time of enrollment;
- c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;
- d. Does not have any other domestic partner or spouse of the same or opposite sex;
- e. Is not currently legally married to anyone or legally separated from anyone else;
- f. Is not a blood relative any closer than would prohibit marriage in Arizona;
- g. Was mentally competent to consent to contract when the domestic partnership began;
- h. Is not acting under fraud or duress in accepting benefits;
 - i. Is at least 18 years of age; and
- j. Is financially interdependent with the retiree in at least three of the following ways:
 - i. Having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
 - ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
 - iii. Assuming joint liabilities;
 - iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
 - v. Naming the partner as beneficiary on the retiree's life insurance, under the retiree's will, or retiree's retirement annuities and being named by the partner as beneficiary of the partner's life

insurance, under the partner's will, or the partner's retirement annuities; and

- vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
- vii. Other proof of financial interdependence as approved by the Director.

The packet can be obtained by calling the ASRS Member Advisory Center (MAC) at (602) 240-2000 (Phoenix Area), (520) 239-3100 (Tucson Area), (800) 621-3778 (all other Area's of the state) weekdays from 8 AM to 5 PM.

What is the ASRS Health Insurance Advisory Committee?

The ASRS has convened a committee of retiree representatives from various major public employee and retiree associations as well as the state's other retirement system and plans. The committee is charged with the responsibility for making recommendations to the ASRS Operations Committee of the Board regarding ASRS retiree health insurance plans; educating itself about the substantive issues affecting senior health care; serving as a sounding board for ideas and concerns to prevent or minimize systemic problems in the administration of

retiree health care; and, providing insight and representation on the direction of "their" and "your" health care plans.

Committee members represent the following organizations:

- AZ Education Association – Retired
- AZ Federation of State, County, and Municipal Employees
- AZ Association of School Business Officials
- All AZ School Retirees Association
- ASU Retirees Association
- NAU Retirees Association
- Arizona State Retired Employees Association
- Public Safety Personnel Retirement System
- League of Cities and Towns
- Maricopa County Community College Retiree Association
- UA Retirees Association
- AZ School Administrators' Association
- Corrections Officer Retirement Plan
- Elected Officials' Retirement Plan
- Arizona State Retirement System

What if I have questions or need additional help?

Questions may be directed to:

ASRS MEMBER SERVICES

Monday-Friday, 8 A.M.– 5 P.M.

Phoenix: (602) 240-2000

Tucson: (520) 239-3100

Outside Metro areas: (800) 621-3778

Hearing Impaired: (602) 240-5333

Please listen to the voice menu as it will assist you in speaking with the most appropriate person for your questions.

If applicable, questions may also be directed to **Public Safety Personnel Retirement System Member Services staff at (602) 255-5575.**

You may also contact PacifiCare and Assurant Employee Benefits directly for assistance. Phone numbers and web addresses are located on the inside back cover of this guide.

ASRS Retiree Medical Plans

For 2009, PacifiCare, a UnitedHealthcare Company, will be the sole provider offering medical benefits to eligible public sector retirees and LTD recipients and their eligible dependents through the Arizona State Retirement System.

Depending upon where you live and whether you are eligible for Medicare, PacifiCare has the following plans from which to choose: a Medicare eligible Health Maintenance Organization (MedicareComplete), a Medicare Supplement Plan that acts as a secondary payer to Medicare (Senior Supplement Plan), a non-Medicare Health Maintenance Organization (HMO), a non-Medicare Preferred Provider Organization (PPO), and a non-Medicare Indemnity Medical Plan.

Non-Medicare Eligible Plans

Health Maintenance Organization (HMO)

Health Maintenance Organization (HMO) requires that all your care be provided through HMO contracted providers, except emergencies. Each family member selects his or her Primary Care Physician (PCP) who may be a Family Practice, General Practice or Internal Medicine Physician. Your PCP will take care of most of your medical needs. Should you require a specialist, tests or hospitalization, your PCP will make the arrangements. **Physician and network names are required on the enrollment form if you select the HMO plan.** Provider directories are available upon request.



Preferred Provider Organization (PPO)

Preferred Provider Organization (PPO) has a network of participating hospitals, doctors, specialists and other medical providers who have agreed to discount fees. However, with the PPO plan, you are free to use any eligible licensed provider for your care. Utilizing a participating provider limits your out-of-pocket expense. Non-participating providers are paid at usual, customary and reasonable (UCR) cost after the plan deductible. Non-participating providers may bill you for amounts over UCR.

Indemnity Medical Plan

Indemnity Medical Plan allows you freedom of choice to see any licensed provider and is paid at UCR after the plan deductible. The providers may bill you for amounts over UCR. This plan is available to non-Medicare retirees who live outside the state of Arizona.

Medicare Eligible Plans

MedicareComplete Plan

MedicareComplete Plan is a plan for members who are enrolled in Medicare Parts A & B and in which PacifiCare has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare. This contract authorizes PacifiCare to provide comprehensive health services to persons who are entitled to original (traditional) Medicare benefits and who choose to enroll in the MedicareComplete Plan. By enrolling in the MedicareComplete Plan, you have made a decision to receive all your routine health care from PacifiCare contracted providers. If you receive services from a non-contracted provider without prior authorization, except for emergency services, out-of-area urgently needed services and renal dialysis, neither PacifiCare nor Medicare will pay for those services.

Physician and network names are required on the enrollment form if you select the MedicareComplete Plan. Provider directories are available upon request. The plan is an approved Medicare medical plan with an approved Medicare prescription drug plan.

Senior Supplement Plan

Senior Supplement Plan is for members who are enrolled in both Medicare Parts A & B. With Senior Supplement you have the freedom to obtain medical care from any physician and hospital that accepts Medicare. The plan is an approved Medicare medical plan with an approved Medicare prescription drug plan.

What Medical Plan Am I Eligible For?

Medicare Eligible Retirees:

Retirees and/or dependents residing in:

- **Maricopa, Pima, Pinal, Coconino, Yavapai, La Paz, Yuma, Cochise, Santa Cruz, Graham and Greenlee counties** with Medicare Parts A and B may select either the MedicareComplete Plan or Senior Supplement.
- **All other counties and states nationwide** with Medicare Parts A & B will have coverage through Senior Supplement Plan.

Non-Medicare Eligible Retirees:

Retirees and/or dependents residing in:

- **Maricopa, Pima and Pinal counties** who are not Medicare eligible can select either the HMO or PPO plans.
- **All other counties within Arizona** who are not Medicare eligible will have coverage under the PPO plan and, with restrictions, under the HMO plan (see Question 8 on page 66).
- **A state outside the State of Arizona** who are not Medicare eligible will have coverage under the Indemnity Medical Plan.

Becoming Medicare Eligible



If you or your dependent will become Medicare eligible on your or their next birthday, there may be changes in your medical coverage, premiums or premium benefit that you need to know about. The address of your primary residence will dictate the Medicare plan for which you are eligible.

You will need to complete a new enrollment form and the Statement of Understanding (SOU), if applicable (see page 55). Please remember that your enrollment form and SOU may **NOT** be dated and signed more than 90 days prior to your effective date of coverage.

Please send the enrollment form, the SOU and a copy of your Medicare card(s) showing Parts A & B or a copy of your Medicare Award letter to ASRS (or, PSPRS, if applicable), 30 days **prior** to the effective date of your Medicare coverage. **Medicare becomes effective the first day of the month of your 65th birthday** (if your birthday is the first of the month, then the effective date is the month before). **The effective date of your ASRS medical coverage will be effective the first of the month following receipt of your enrollment form and SOU.** Therefore, simultaneous enrollment in Medicare and an ASRS medical plan is important.

A new ID card(s) and Certificate(s) of Coverage for your new medical plan will be sent by PacifiCare after your forms have been processed.

Disenrollment Form

The Disenrollment Form must be completed and signed by all Medicare eligible retirees and/or dependents who are currently enrolled in the MedicareComplete or the Senior Supplement Plans and who are dropping that coverage. This form requests that your health care coverage revert back to

the traditional Medicare fee-for-service program. The effective date will be the first day of the month following receipt of the Disenrollment Form, unless a future date is requested. Submission of a properly completed enrollment form "declining" coverage is also required.

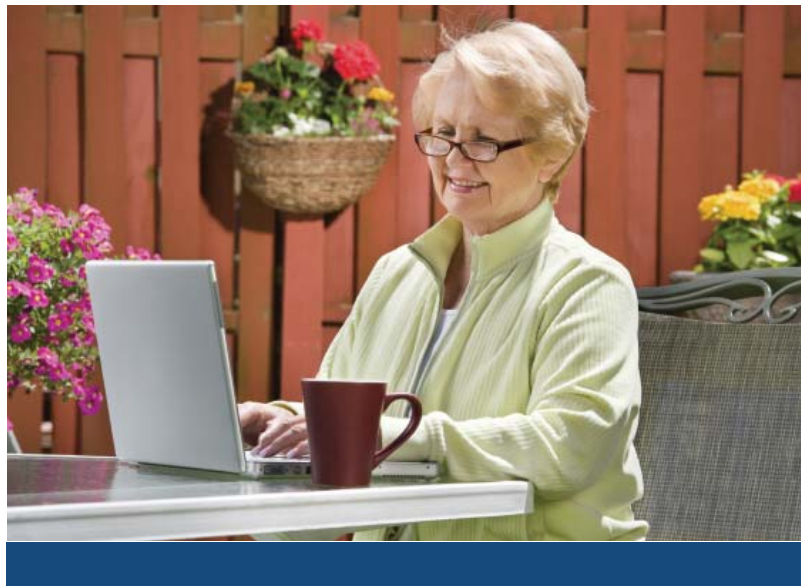
Comparison of Benefits

The medical plan comparison charts on the following pages contain a partial listing of the benefits offered to Medicare eligible and non-Medicare eligible retirees, LTD recipients and eligible dependents. Please remember that benefits are subject to plan limitations and exclusions.

After you enroll for coverage, PacifiCare will send you an Identification (ID) Card and an Evidence of Coverage booklet for the HMO plans or a Certificate of Coverage for the PPO, Indemnity Medical and Senior Supplement Plans. Please review these documents before you begin to use services so you understand the terms and conditions of the plan you selected.

A glossary begins on page 72 for definitions of many of the terms used in the charts.

Questions concerning your plan should be directed to the PacifiCare Customer Service number listed on the back of your ID card or inside the back cover of this guide.



PacifiCare®

A UnitedHealthcare Company

2009 Medicare Eligible Retiree Medical Plans Comparison Chart

The information contained in this chart is a partial summary of the medical benefits offered by PacifiCare for Medicare eligible retirees, disabled members, and eligible dependents. It also serves as a comparison between plans.

Outpatient Benefits	MedicareComplete (Secure Horizons)	Senior Supplement		
	Member Pays	Medicare Pays	Supplement Pays	Member Pays
Doctor Office Visit	\$15 Copayment	80% of MAC* After \$135 Deductible	Deductible then 20% of MAC*	No Charge
Specialist Office Visit	\$30 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	Subject to Medicare Guidelines
Routine Physical	No Charge	Not Covered	Not Covered	All Costs
Examinations/ Immunizations	\$15 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Outpatient Mental Health	\$30 Copayment	50% of MAC* after Deductible	Deductible then 50% of MAC*	\$0
Outpatient Surgical Services	\$100 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
X-Rays Outpatient-Standard Outpatient-Specialized Scans	No Charge \$50 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Outpatient Lab Tests	No Charge	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Durable Medical Equipment	No Charge	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Skilled Nursing Facility	No Charge Limit of 100 days per Benefit Period	Days 1–20: 100% of MAC* Days 21–100: All but \$119 per day Days over 101: \$0	Days 1–20: \$0 Days 21–100: \$119 per day Days over 101: \$0	Days 1–20: \$0 Days 21–100: \$0 Days over 101: All Costs
Home Health Care	No Charge	100% of MAC*	\$0	\$0
Physical, Speech and Occupational Therapy	\$15 Copayment	80% of MAC*	Deductible then 20% of MAC*	\$0

* Medicare Approved Charges (MAC)

2009 Medicare Eligible Retiree Medical Plans Comparison Chart

Inpatient Benefits	MedicareComplete (Secure Horizons)	Senior Supplement		
	Member Pays	Medicare Pays	Supplement Pays	Member Pays
Inpatient Hospital Expenses	\$100 per admission	Subject to Medicare Guidelines	Subject to Medicare Guidelines	\$0 unless lifetime maximum has been used
Inpatient Mental Health	\$100 per admission 190 days Lifetime	Subject to Medicare Guidelines	Subject to Medicare Guidelines	\$0 up to 190 days lifetime
Prescription Benefits				
Tier 1/Tier 2 (Generic/Brand)	\$20/\$40 Copay		All But Member Copay to \$2700 Annual Max	\$10/\$35 Copay**
Mail Order (90-day Supply)	\$40/\$80 Copay	\$0		\$20/\$70 Copay**
Other Benefits				
Emergency Room	\$50 Copayment (waived if admitted)	80% of MAC*	20% of MAC*	\$0
Urgent Care Facility	\$15 Copayment	80% of MAC*	20% of MAC*	\$0
Ambulance	\$25 Copayment	80% of MAC*	20% of MAC*	\$0
Other				
Hearing Exam/Aids	No Charge / \$500 Allowance Every 3 Yrs	Not Covered	Not Covered	All Costs
Deductible	None	\$0 per Person Outpatient Services	\$135 per Person Outpatient Services	\$100* cal. yr. deductible for inpatient & outpatient services
Maximum Lifetime Benefit	No Maximum	No Maximum	up to \$2,000,000	All costs over \$2,000,000
Vision Exam	\$20 Copayment	Not Covered	\$80 Allowance Per Calendar Year	\$20 Deductible Plus All Cost Above Allowance
Lenses and Frames	\$130 Allowance per Calendar Year	Not Covered	\$130 Allowance Per Calendar Year	All Cost Above Allowance
SilverSneakers Fitness Program	Free Membership at Participating	\$0	Free Membership at Participating Clubs***	\$0

* Medicare Approved Charges (MAC) ** Member pays copay up to \$2,700.00 in Total Drug Expenditures.

Member then pays 100% of prescription costs until \$4,350.00 in True Out-of-Pocket costs has been met.

Member then pays \$2.40 generic, \$6.00 brand co-pay or 5% whichever is greater. *** See page 47-49 for more details.

Important Note: This is only a brief summary of benefits. Please refer to the plan's Evidence of Coverage for a list of benefits and exclusions specific to the ASRS retiree medical plan. UnitedHealthcare will send you an Evidence of Coverage with complete information on the benefits, limitations and exclusions once your enrollment form is processed.

Your Medicare Benefits

Your Medicare benefits are provided by the Federal Government and integrated through the ASRS Retiree Medical Plans. In order for a Medicare eligible ASRS retiree to be covered by an ASRS medical plan, the

retiree and, if family coverage is elected, his/her eligible dependent(s) who qualify for Medicare, must be enrolled in both Parts A and B of Medicare. Failure to enroll in

MEDICARE PART A: 2008*			
Services	Benefit	Medicare Pays	You Pay
Hospitalization Semiprivate room and board, nursing and other hospital services and supplies.	First 60 days	All costs less \$1024	\$1024
	61st to 90th day	All costs less \$256/day	\$256/day
	91st to 150th day	All costs less \$512/day	\$512/day
	Beyond 150 days	Nothing	All costs
Skilled Nursing Facility (SNF) Care** Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies.	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All costs less \$128/day	\$128/day
	Beyond 100 days	Nothing	All costs
Home Health** Part-time skilled nursing, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay nothing 100% of approved amount for Home Health Care		20% of approved amount for durable medical equipment
	Have questions: Call your Regional Home Health Intermediary. Consult your Medicare booklet.		
Hospice Care** Medical and support services from a Medicare-approved hospice, drugs for symptom control & pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	Copayment of up to \$5 for outpatient prescription drugs. You pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient by another caregiver so that the usual caregiver can rest). If you have questions about Hospice care and conditions of coverage, call your Regional Intermediary. Consult your Medicare booklet.		
Blood Given at a hospital or skilled nursing facility during a covered stay.	You pay for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood after the deductible.		

*You pay nothing for Part A of Medicare. You paid for Part A while you were employed and making FICA contributions.

**You must meet certain conditions in order for Medicare to cover these services. Consult your Medicare booklet.

Note: Actual amounts you must pay are higher if the doctor does not accept Medicare assignment.

Your Medicare Benefits

Medicare when the retiree becomes eligible will cause a delay in ASRS medical plan coverage.

These two pages contain a summary of Medicare coverage and premiums currently in effect for 2008.

If you wish additional information, contact the Centers for Medicare and Medicaid Services (CMS) either by phone 1-800-633-4227 or at their website at www.medicare.gov.

PLEASE NOTE: At the time of this printing, Medicare had not released 2009 benefit levels.

MEDICARE PART B: 2008*

Services

Medical and Other Services Doctor's services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers). Also covers outpatient physical and occupational therapy including speech-language therapy and mental health services.	You Pay: \$135 deductible (pay per calendar year). 20% of approved amount after the deductible, except in the outpatient setting. 20% for all outpatient physical, speech therapy services occupational therapy services. 50% for most outpatient mental health services.
Clinical Laboratory Service Blood tests, urinalysis and more.	You Pay: Nothing for Medicare-approved services.
Home Health Care** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care and other services.	You Pay: Nothing for services. 20% of approved amount for durable medical equipment.
Outpatient Hospital Services Services for the diagnosis or treatment of an illness or injury.	You Pay: 20% of approved amount after the deductible.
Blood Pints of blood needed as an outpatient or as part of a Part B covered service.	You Pay: For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood after the deductible.

*For 2008, the usual monthly Medicare Part B premium is \$96.40 (see page 70 for more information).

** You must meet certain conditions in order for Medicare to cover these services. Consult your Medicare booklet.

Note: Actual amounts you must pay are higher if the doctor does not accept Medicare assignment.

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

The information contained in this chart is a partial summary of the medical benefits offered by PacifiCare for Non-Medicare eligible retirees, disabled members and dependents. It also serves as a comparison between plans.

Outpatient Benefits	HMO	INDEMNITY
	Member Pays	Plan Pays
Doctor Office Visits	\$20 Copayment	
Specialist Office Visit	\$40 Copayment	80%*
Routine Physical	\$20 Copayment	80%*
Examinations/ Immunizations	\$20/\$40 Copayment	80%*
Vision Examination	\$40 Copayment	Not Covered
Hearing Examination	\$40 Copayment	Not Covered
Outpatient Mental Health	\$40 Copayment	80%*
Outpatient Hospital Services	30%	80%*
X-Rays Outpatient – Standard	\$20 Copayment	80%*
Outpatient – Specialized Scans	\$150 Copayment	80%*
Outpatient Lab Tests	No Charge	80%*
Durable Medical Equipment	No Charge	80%*
Prosthetic Devices	50%	80%*
Skilled Nursing Facility	No Charge	80%*
Home Health Care	No Charge	80%*
Physical, Speech and Occupational Therapy	\$40 Copayment	80%*

* Subject to Calendar Year Deductible

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

PPO	
In-Network Plan Pays	Out-of-Network Plan Pays
100% after \$15 Copayment	60%*
100% after \$15 Copayment	60%*
100% after \$15 Copayment	60%*
Not Covered	Not Covered
Not Covered	Not Covered
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*
80%*	60%*

* Subject to Calendar Year Deductible

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

	HMO	INDEMNITY
Inpatient Benefits	Member Pays	Plan Pays
Inpatient Hospital Expenses	30%	\$500 Admission Deductible then 80%*
Inpatient Mental Health	30%	\$500 Admission Deductible then 80%*
Prescription Benefits	Formulary	Formulary
Generic/Brand	\$20/\$40 Copay	\$20/\$40 Copay
Mail Order (90 day supply)	\$40/\$80 Copay	\$40/\$80 Copay
Other Benefits	Member Pays	Plan Pays
Emergency Room	\$75 Copayment (waived if admitted)	\$75 deductible (waived if admitted)
Urgent Care Facility	\$40 Copayment	80%*
Ambulance	No Charge	80%*
Lenses and Frames	Allowances**: \$50 Lenses and \$50 Frames or \$100 Contacts	Not Covered
Hearing Aids	\$200 Allowance per calendar year	Not Covered

* Subject to Calendar Year Deductible

** Members on the non-Medicare plan must use Eye Specialist of Arizona in order to obtain their vision benefits. Please check the provider directory for office listings.

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

PPO	
In-Network Plan Pays	Out-of-Network Plan Pays
80%*	\$500 Admission Deductible then 60%*
80%*	60%*
Formulary	Formulary
\$20/\$40 Copay	\$20/\$40 Copay
\$40/\$80 Copay	\$40/\$80 Copay
In-Network Plan Pays	Out-of-Network Plan Pays
\$75 deductible (waived if admitted)	\$75 deductible (waived if admitted)
80%*	60%*
70%*	70%*
Not Covered	Not Covered
Not Covered	Not Covered

* Subject to Calendar Year Deductible

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

Other	HMO	INDEMNITY
	Member Pays	Plan Pays
Calendar Year Deductible	None	\$500 per Individual \$1,000 per Family
Inpatient Hospital Deductible	None	\$500 per admission
Outpatient Surgical Services Deductible	None	\$250 per visit
Out of Pocket/ Coinsurance Maximum	\$3,000 per Individual \$9,000 per Family	\$2,000 per Individual \$4,000 per Family excluding the deductibles
Maximum Lifetime Benefit	No Maximum	\$2,000,000
SilverSneakers Fitness Program	Free Membership at Participating Clubs**	Not Covered

** See pages 47-49 for more details.

2009 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

PPO	
In-Network Plan Pays	Out-of-Network Plan Pays
\$500 per Individual \$1,000 per Family	
None	\$500 Out-of-Network Hospital per admission
None	\$250 Out-of-Network Hospital per visit
\$2,000 per Individual \$4,000 per Family excluding the deductibles and copayments	\$6,000 per Individual \$12,000 per Family excluding the deductibles and prescription drug copayments
\$2,000,000	
Free Membership at Participating Clubs**	

** See pages 47-49 for more details.

Important Note: This is only a brief summary of benefits. Please refer to the plan's Certificate of Coverage or Evidence of Coverage for a list of benefits and exclusions specific to the ASRS retiree medical plan. PacifiCare will send you a Certificate of Coverage with complete information on the benefits, limitations and exclusions once your enrollment form is processed.

ASRS Retiree Medical Plans


Sample ID Cards

The sample ID cards below show you which card belongs to which PacifiCare-sponsored ASRS retiree medical, prescription and vision plan. These sample ID cards will help you identify the medical plan in which you are enrolled as well as the number and kinds of different cards you should have.

For retirees enrolled in **PacifiCare Secure Horizons Medicare Complete Plan**, your ID card is a medical, vision and prescription drug plan ID card.

If you are an existing member and are not changing plans, you will continue to use the card you previously received.

For new members (effective January 1, 2009), your card will look like this:

	
Health Plan (80840) [911- 87726 -01]	
Member ID: [999999876]	Group Number [987654]
Member:	[GROUP NAME]
[FIRST M LAST]	[SECOND LINE OF GROUP NAME]
PCP Name:	Payor ID
[DR PROVIDER BROWN]	[87726]
PCP Phone: [(800) 123-4567]	MedicareRx <small>Prescription Drug Coverage</small> Rx Bin 610014 Rx Grp UHEALTH Rx PCN 9999 [Copay: Tier1 / 2 / 3/ SPC] [\$20/\$40/\$40/\$40]
[MEDICAL GROUP]	
[Copay: Ov / Spec / ER] [\$15/\$30/\$50]	
[H12345 PBP#001]	[Insured by United HealthCare Insurance Company]

For retirees enrolled in **PacifiCare Senior Supplement**, you have separate ID cards for your medical/vision plan and for your prescription drug plan. Your prescription drug card bears the name "UnitedHealth Rx". Your cards look like these:

PacifiCare® <i>Retiree Plans™</i>	Senior Supplement Plan
JOHN Q. DOE DOB: 01-01-1953 ID #: 000000000-01 EFF. DATE: 08-01-2004	
GROUP #: 00010365 GROUP NAME: ARIZONA STATE RETIREMENT	
UNDERWRITTEN BY: PacifiCare Life and Health Insurance Company	

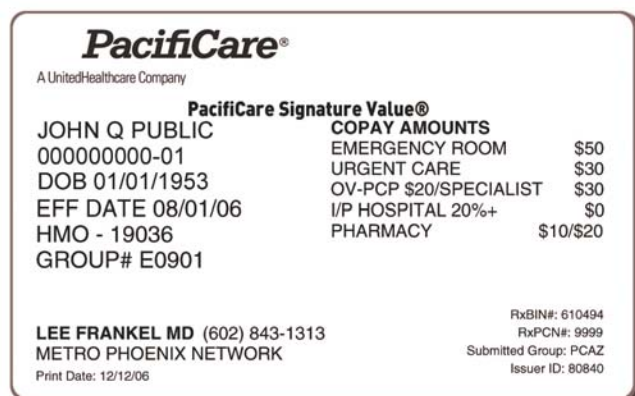
	
<UnitedHealth Rx for Groups>	
RxBin	<XXXXXX>
RxPCN	<XXXXXXXX>
RxGrp	<XXXXXXXX>
Issuer	<80840>
ID	<XXXXXXXXXX>
Name	<FirstName_MI_LastName>
[Plan Member since: <year>]	<CMS contract #> <PBP#>
MedicareRx <small>Prescription Drug Coverage</small>	

ASRS Retiree Medical Plans

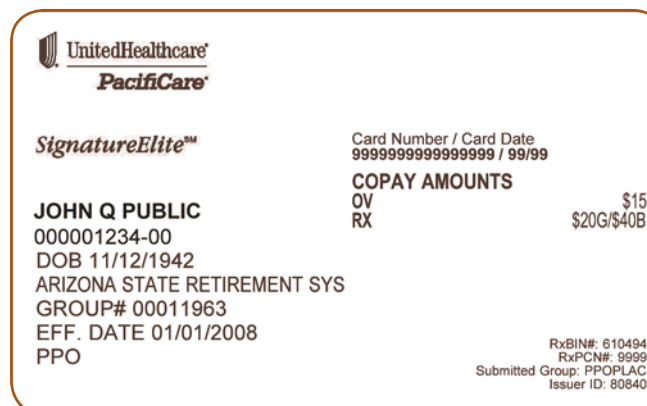
Sample ID Cards

For retirees enrolled in PacifiCare's HMO, PPO, or Indemnity medical plans, your ID card is both a medical and a prescription drug plan ID card. They look like these:

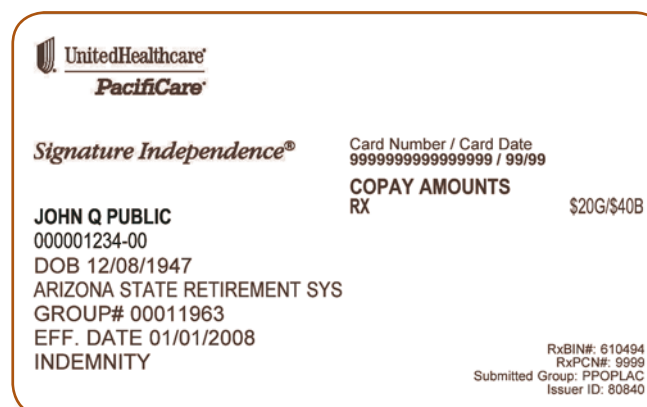
For PacifiCare's **HMO medical plan**, you have a PacifiCare "Signature Value" ID card.



For PacifiCare's **PPO medical plan**, you have a Pacificare "SignatureElite" ID card.



For PacifiCare's **Indemnity medical plan**, you have a PacifiCare "Signature Independence" ID card.



Understanding the ASRS Medicare Eligible Retiree Prescription Drug Plans

The ASRS offers two different medical plan options each with prescription drug coverage for Medicare eligible retirees and dependents.

MedicareComplete® Plan

The name for the SecureHorizon Medicare Advantage Plan is MedicareComplete® Plan.

Prescription drug plan features:

- No prescription drug plan deductible
- \$20 generic drugs and \$40 brand name for up to a 31 day supply at contracted retail pharmacy
- \$40 generic drugs and \$80 brand name for up to a 90 day supply through the prescription by mail program
- No coverage gap or annual benefit limit in coverage
- Catastrophic Coverage: After your true out-of-pocket expenses reach \$4,350 you begin catastrophic coverage and pay whichever is higher: a \$2.40 co-payment for generic drugs; a \$6.00 co-payment for brand name drugs, or 5% of the drug costs until the end of the calendar year.
- Standard SecureHorizons formulary applies. National network of contracted retail pharmacy locations (national chains and local pharmacies). To find a pharmacy near you, visit www.SecureHorizons.com.
- Convenient prescription by mail program

Senior Supplement Plan + UnitedHealth Rx for Groups prescription drug coverage

The name / brand for the Senior Supplement Plan prescription drug coverage is UnitedHealth Rx for Groups.

Prescription drug plan features:

- No prescription drug plan deductible
- Low copayments:
 - \$10 generic drugs and \$35 brand name for up to a 31 day supply at contracted retail pharmacy
 - \$20 generic drugs and \$70 brand name for up to a 90 day supply through the prescription by mail program
- “Open formulary” plan design (some prior authorization requirements may apply)
- Coverage gap begins after \$2,700 in total drug costs in 2009
- In the coverage gap the member pays 100% of the cost of the drugs.
- Catastrophic Coverage: After your true out-of-pocket expenses reach \$4,350 you begin catastrophic coverage and pay whichever is higher: a \$2.40 co-payment for generic drugs; a \$6.00 co-payment for brand name drugs; or 5% of the drug costs until the end of the calendar year.
- National network of contracted retail pharmacy location (national chains and local pharmacies). To find a pharmacy near you, visit www.SecureHorizons.com.
- Convenient prescription by mail program

PLEASE NOTE: if you enroll in any

Understanding the ASRS Medicare Eligible Retiree Prescription Drug Plans

Medicare prescription drug plan in addition to one of the ASRS plan options, you will become ineligible for both medical and prescription drug coverage under the ASRS plan, and will be automatically disenrolled. **Medicare allows you to be enrolled in only one prescription drug plan at a time.**

Enrollment in a Medicare prescription drug plan is an option, not a requirement. You do not have to enroll in a separate Medicare Part D prescription drug plan.

However, both Medicare prescription

drug plans offered by ASRS are equal to or better than the standard Medicare coverage. When an eligible ASRS Medicare beneficiary is enrolled in either of the ASRS-sponsored prescription drug plans when first eligible for Medicare prescription drug coverage, there is no enrollment penalty as outlined above if you should enroll in an individual Medicare Part D prescription drug plan at a future date.



The Senior Supplement Prescription Drug Plan

I am enrolled in the Senior Supplement Plan. How does the UnitedHealth Rx for Groups prescription drug plan work for me?

Each time you purchase a covered prescription medication, two payments are actually being made: the payment you pay out of your pocket for the drug, called true out-of-pocket (TrOOP) costs, and the payment your plan pays for the drug. Together these payments make up your "total drug costs".

What is my initial prescription drug coverage (Stages 1 and 2)?

Under the UnitedHealth Rx for Groups prescription drug plan, there is no prescription plan deductible. For all covered prescription drugs you simply pay your generic or brand copayments for the first \$2,700 of "total drug costs" during 2009.

When does the coverage gap (Stage 3) begin?

The coverage gap begins after you and the plan together have spent \$2,700 in "total drug costs" during the year. During the coverage gap, you pay 100% of your drug costs.

When does the coverage gap end (Stage 4)?

The coverage gap ends when your true out-of-pocket costs reach \$4,350 and you begin catastrophic coverage. When you reach Stage 4, you will pay whichever is higher: a \$2.40 co-payment for generic drugs; a \$6.00 co-payment for brand-name drugs; or, 5% of the drug costs until the end of the calendar year.

Medicare Part D Benefit

STAGE 1: Annual Deductible

Your plan has no annual deductible.

STAGE 2: Initial Coverage

You pay copays for each prescription filled; the plan pays remainder until together you have paid \$2,700 in total drug costs.

STAGE 3: Coverage Gap

You pay 100% of your drug costs until your yearly true out-of-pocket drug costs equal \$4,350.

STAGE 4: Catastrophic Coverage

After \$4,350 in out-of-pocket drug costs, the plan pays the majority of the drug expenses until the end of the year.

Please note: the coverage gap referenced above applies ONLY to the UnitedHealth Rx for Groups prescription drug plan offered with the Senior Supplement plan. There is no coverage gap with the Medicare Complete® prescription drug plan.

Rx Summaries Provided

The Medicare prescription drug plans provide a monthly prescription benefit summary tailored specifically to individual Medicare members. The summary helps you:

- Understand how much you and your drug plan spent to-date on prescription drugs
- Details your prescription history to help lower monthly spending
- Review prescriptions, including fill dates, prescribing doctor and pharmacy information

General Information About PacifiCare's Prescription Drug Benefits

What is a Formulary and why is it important?

PacifiCare keeps your medication costs down through a Formulary. The Formulary is a list of PacifiCare-approved outpatient prescription drugs that are covered under the PPO, Indemnity Medical, HMO and Medicare Complete plans. A pharmacy and therapeutics committee that consists of practicing physicians and pharmacists determines and maintains the Formulary. The committee decides which prescription drugs provide quality treatment for the best value. It includes a broad range of generic and brand name drugs, although it does not include all prescription drugs.

What medical plans utilize the Formulary?

The PPO, Indemnity Medical, HMO and Medicare Complete plans utilize the Formulary. For you to receive prescription drug benefits, your physician must prescribe medication for you from the Formulary and the prescription must be filled at a participating pharmacy.

Do I have a Prescription Drug Formulary in the Senior Supplement Plan?

The Senior Supplement Plan utilizes the Medicare Part D formulary. Medicare, not PacifiCare, determines what drugs are covered under the Senior Supplement Medicare Part D plan. Check with your doctor as some drugs may not be covered.

What is covered?

All medications listed in the Formulary are covered. In order to receive your prescription benefits, your physician must prescribe medication for you from the Formulary and the prescription must be filled at a participating pharmacy.

What if my prescription is not listed in the Formulary?

Your physician can contact Prescription Solutions, PacifiCare's prescription manager, for an exception explaining why you must have that drug rather than the one on the Formulary or your physician must change your prescription to an equivalent Formulary drug.

What is the difference between brand name and generic drugs?

A generic drug is a medication which has met the standards set by the Food and Drug Administration (FDA) to assure its equivalence to the original patented brand name medication. Generic drugs are chemically identical to their brand name equivalents. Many brand name drugs do not have generic equivalents. In these cases, your physician may prescribe a "therapeutic" instead. Unlike generic drugs which have the identical active ingredients as a brand name version, a therapeutic substitute has a chemical composition close to its brand name counterpart and has been determined to provide the same clinical or therapeutic results.

How can I obtain a copy of the Formulary?

The Formulary is available upon request from PacifiCare or SecureHorizons and can also be found on their website at www.pacificare.com or www.securehorizons.com. The name of the SecureHorizons formulary is "standard".

How can I save money by using the Prescription Mail Order Program?

Prescription Solutions, PacifiCare's prescription manager, offers a mail order program for maintenance medications. Through the mail order program, you can order a three (3) month supply of medications and save money on your prescription copayment. Prescriptions are mailed to your home in discreetly labeled packages. Refills can be ordered by mail, over the phone or through the Internet. Mail Order Claim forms may be ordered through PacifiCare's Customer Service or their website at www.pacificare.com.

Pacificare's Vision Care Benefits

Secure Horizons Medicare Complete Plan

Your medical plan covers one eye exam per year and medically necessary glasses or lenses following cataract surgery. Your Routine Prescription Eyewear benefit provides a routine exam, eyeglasses or contact lenses for routine vision correction.

If you need the services of an eye specialist, you should call Secure Horizons Customer Services at 866-622-8055 for the nearest Participating Provider. For a routine eye exam you may go to a Spectera vision provider. In both instances, the vision eyewear is only available through the Spectera vision network. Locate a vision provider near

you by either going to www.spectera.com or calling Spectera Vision Customer Service at 1-800-638-3120, (or for the hearing impaired 1-800-524-3157). Enjoy receiving care at Vision centers that are convenient and have extended hours such as Wal-Mart, Sam's Club, Nationwide Vision and Eyemasters. The vision network is provided by Spectera.

At a Spectera network vision center, you can receive routine eye exams (also called refractive eye exams) for a \$20 co-payment, eyeglass lenses (single, bifocal and trifocal) are covered in full, and you have a \$130 retail allowance toward frames. In lieu of eyeglasses, there is \$105 allowance toward contacts. Exams, lenses and frames are covered once every 12 months. You will be responsible for any charges in excess of the \$130 frame allowance or the \$105 contact lens allowance.

This vision care plan is designed to cover your vision needs rather than cosmetic materials. However, most lens options are available at a discount.

If you have questions about this plan you may call Spectera Vision Customer Service at 1-800-638-3120, (or for the hearing impaired 1-800-524-3157), Monday through Friday, 8 a.m. to 11:00 p.m. EDT and Saturday, 9:00 a.m. to 6:30 p.m. EDT.



Pacificare's Vision Care Benefits

PacifiCare Senior Supplement Plan

Your Routine Prescription Eyewear benefit provides eye refraction, eyeglasses or contact lenses for routine vision correction.

You have the choice of any vision provider, but you receive the greatest savings by using a Spectera network provider. To locate a vision provider near you, go to www.spectera.com or call Spectera Customer Service at 1-800-638-3120, (or for the hearing impaired 1-800-524-3157). You may then schedule an appointment for your vision exam. Enjoy the greatest savings at vision centers that are convenient and have extended hours, such as Wal-Mart, Sam's Club, Nationwide Vision and Eyemasters. The vision network is provided by Spectera. Please confirm your provider is participating in the new network before making an appointment.

At a Spectera network provider, after a \$20 deductible, you have coverage for routine eye exams (also called refractive eye exams). Standard eyeglass lenses (single, bifocal and trifocal) are covered in full, and you have

a \$130 retail allowance toward frames. In place of eyeglasses, there is \$105 allowance toward contacts. Exams, lenses and frames are covered once every 12 months. If you chose not to use a Spectera Network vision provider, there is an \$80 allowance toward the routine examination after satisfying a \$20 deductible. Your eyewear benefit is \$100 toward the purchase of eyeglasses, or contact lenses in place of eyeglasses. You will be responsible for charges in excess of the \$100 allowance. You are eligible to receive this benefit once every 12 months.

This vision care plan is designed to cover your vision needs rather than cosmetic materials.

If you have questions about this plan you may call Spectera Customer Service at 1-800-638-3120, (or for the hearing impaired 1-800-524-3157), Monday through Friday, 8 a.m. to 11:00 p.m. EDT and Saturday, 9:00 a.m. to 6:30 p.m. EDT.

Benefit limited to 1 time every 12 months	In-Network You Pay	Out-of Network You Pay
Deductible	\$20	\$20
Routine Eye Refraction (examination)	\$0 after deductible satisfied	Charges in excess of \$80
Eyeglass Lenses (single, bifocal and trifocal)	\$0 covered in full	Charges in excess of \$100 for Lenses, Frames, or contacts combined
Eyeglass Frames	Charges in excess of \$130 retail allowance	
Contact Lenses (in place of eyeglasses)	Charges in excess of \$105 allowance	

ASRS Retiree Dental Plans

For 2009, Assurant Employee Benefits will again be the sole provider offering dental benefits to eligible public sector retirees, LTD recipients and eligible dependents through the Arizona State Retirement System. Assurant offers three different dental plans that allow you to choose between the Freedom Advance or Freedom Basic indemnity dental plans, and a prepaid dental plan. These plans provide you with the freedom to choose a dental plan that best fits your individual needs. Compare the cost and benefits of each dental plan to determine which plan will meet the dental health needs of you and your family.

PLEASE NOTE: There are *significant* differences between the indemnity and prepaid plans. Below is a brief synopsis of features of the two indemnity plans and the prepaid plan.

Indemnity Dental Plans

These plans pay the indicated percentages of Allowable Charges for covered services. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum which is \$2,500 for the Freedom Advance and \$1,000 for the Freedom Basic Indemnity Dental Plans. You are responsible for any applicable coinsurance percentages not covered by the plans. Allowable charges are based on charges being made by providers in the area where dental services are performed. The Indemnity Plans feature:

Two Plan Choices:

Freedom Advance

Freedom Basic

Freedom of choice of dentists or use Dental Health Alliance (DHA) participating dentists for savings on all dental services

Nationwide coverage

Benefits underwritten by a financially strong company

Fast, accurate claims service

Vision benefit included (see VSP details on page 45)

Prepaid Dental Plan

The prepaid dental plan provides a variety of benefits through participating dentists. You may change your dentist throughout the plan year (see Question 14 on page 67 "How do I change my General Dentist?"). All services must be performed by a participating provider. You will then be responsible for any co-payments which are reduced fees that you will pay directly to the dentist for covered dental procedures. The Prepaid Dental Plan features:

No deductibles

No claim forms to file

No annual maximums

No waiting periods

Some cosmetic dentistry benefits

Orthodontia for both children and adults

Participating provider directory

Vision benefit included (see VSP details on page 45)

Important Things to Consider When Making Your Dental Plan Election



You have three dental plans from which to choose. They are:

- 1) Freedom Advance Indemnity Dental Plan
- 2) Freedom Basic Indemnity Dental Plan
- 3) Prepaid Dental Plan

- **A Specialty Benefit Amendment (SBA) is included with the Prepaid Dental Plan for Arizona residents** that allows patients to receive certain services from Assurant contracted SBA specialists for a specific copayment rather than the discounted fee.
- If you are a member of either indemnity dental plan and you want to **spend less for your dental treatments and services**, use an Assurant Dental Health Alliance (DHA) participating dentist. By using a participating DHA dentist, Assurant's payment and your coinsurance plus any applicable deductible will be deemed payment in full for the services performed. In addition, any services not covered by your ASRS indemnity dental plan, including cosmetic services and additional cleanings, are offered at reduced fees.
- **If you are selecting the Prepaid Dental Plan** you must choose a Primary Care Dentist from the Assurant Directory of Dentists. Once you have chosen a Primary Care Dentist, **you must enter the Dentist ID number from the directory on your enrollment form.** This is very important! It allows Assurant to tell your chosen General Dentist that you

will be a new patient and includes your dental plan information on the dentist's eligibility list called a "roster."

- The Assurant **indemnity dental plans** offer freedom of choice to use any eligible licensed dentist or specialist in the United States. However, you may use Assurant's Dental Health Alliance (DHA) participating dentists to receive additional savings on all your dental treatment services.

To find the most convenient Assurant DHA participating dentist for your indemnity dental plan from the network of participating DHA dentists, please visit Assurant's special website at www.assurantemployee-benefits.com or call 800-985-9895.

Important Information Regarding On-Going Dental Care If You Are Newly Enrolled with ASRS

If you are actively undergoing major dental procedures with your current dental provider and the service(s) is not completed prior to the effective date of your dental coverage with ASRS, your current provider may allow that on-going procedure to be a covered expense under your current dental plan even after your termination from your employer's dental plan. Check with your current dental provider to learn if your procedure qualifies for continued coverage.

Dental procedures you are receiving from your current non-ASRS dental provider **will not be eligible** for benefits through Assurant.



Assurant Dental Plans

Plans	Deductibles	Type I Preventive Services	Type II Basic Services
Freedom Advance*	\$50/\$150	80% paid (deductible waived) Oral Exam (1x/6 mo.) Routine Cleaning (1x/6 mo.) Fluoride Treatment (1x/12 mo. under age 14) Sealants (1x/perm. molar under age 16) X-rays Bitewings (1x/12 mo.) Full Mouth (1x/60 mo.) Space Maintainers (under age 16)	80% paid (deductible applied) New and Replacement Fillings Emergency Treatment (includes exam/x-rays) Oral Surgery Simple Extractions, Surgical Incision & Drainage of abscess, Root Removal on exposed root Endodontics (Root Canals) Periodontics (Treatment of gum disease)
Freedom Basic	\$50/\$150	100% paid (deductible waived) Oral Exam (1x/6mo.) Routine Cleaning (1x/6mo.) Fluoride Treatment (1x/12mo. Under age 14) Sealants (1x/perm. molar under age 16) X-rays Bitewings (1x/12 mo.) Space Maintainers (under age 16)	80% paid (deductible applied) New and Replacement Fillings Emergency Treatment (includes exam/x-rays) Oral Surgery Simple Extractions X-rays Full Mouth (1x/60 mo.) Panoramic (1x/60 mo.) Minor Periodonics Scaling & Root Planing (1x/24 mo.) Periodontic Maintenance (1x/6 mo.)
Arizona Prepaid Dental Plan Option**	No Deductibles	Fixed co-pays \$0 Oral Exam \$0 most individual x-rays \$0 Bacterial Studies \$10 Routine Office Visit \$10 X-rays-complete series \$10 Routine cleaning/adult (1x/6 mo.) \$85 Space Maintainers-fixed*** \$110-135 Space Maintainers-removable***	Fixed co-pays \$25 Problem-focused Office Visit \$25-130 Fillings (1-4 surfaces) \$185 Cosmetic Bleaching, per arch \$295-395 Root Canal - Molar (excludes final restoration) \$75-355 Gingivectomy or Gingivoplasty, per quad \$25 Single tooth extraction \$165-200 Removal impacted tooth, complete bony

Notes applicable to Dental Plans Comparison Chart:

*All new enrollees in the Freedom Advance (High Option) indemnity dental plan will start at a 25% coinsurance level for Type III Major Services for the 1st year of continuous dental coverage and then graduate to 50% for the 2nd year of continuous dental coverage and each year thereafter.

**Requires you to select a Participating Dental Provider (PDP) when enrolling. In addition, if you are selecting a PDP listed as "roster only," it takes time to get on the roster after enrollment. You must be on the roster prior to receiving non-emergency care.

***Members are responsible for additional lab fees for these services.

"Notes" continued on next page...

Comparison Chart

Type III Major Services	Orthodontia	Annual combined maximum preventive basic and major benefits
25%/ 50% paid* (deductible applied) Major Restorations Inlays/Onlays, Crowns Bridges/Dentures Initial placement-covered Replacement only if 7 yrs. lapsed from date of installation Complex Oral Surgery	Not Covered	\$2500 per person
Not Covered	Not Covered	\$1000 per person
Fixed co-pays \$25 Problem-focused Office Visit \$245-340 Inlays/Onlays*** \$295-Crowns*** \$385-495 Dentures*** \$35-100 Adjustments/Repairs***	25% discount off UCR Available for both Children & Adults	Benefits available only at participating dentist and specialist offices No Dollar limit

"Notes" (continued from previous page):

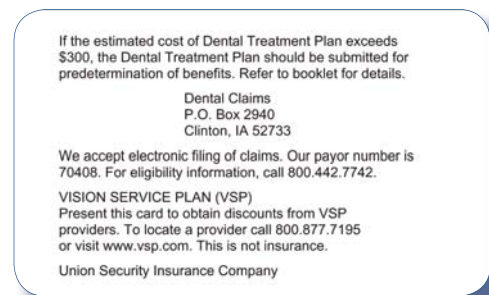
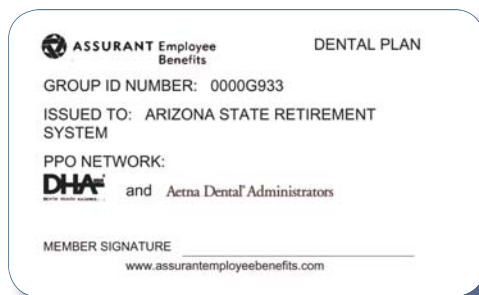
Pre-paid Dental Plans are also available in **CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX, UT**. For a copy of the Schedule of Benefits and Provider Directory in one of these states, please call the Assurant ASRS on-site representative at the number listed on the inside back cover of this guide in the Dental Provider section.

ASRS Retiree Dental Plans

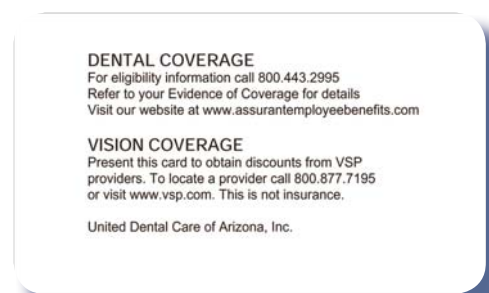
Sample ID Cards

The sample ID cards below show you which ID card belongs to which Assurant-sponsored ASRS retiree dental plan. The card also provides information on Assurant's vision plan offered through Vision Service Plan (VSP).

For retirees enrolled in Assurant's Freedom Advance (High Option) or Freedom Basic (Low Option) indemnity dental plan, your ID card looks like this:



For retirees enrolled in Assurant's Arizona **Prepaid** or other eligible state Prepaid dental plans, your ID card looks like this:



Note: Vision Service Plan (VSP) information is located on the back side of each ID card.

Vision Service Plan (VSP) Discount Benefit

Your Assurant Employee Benefits dental plan includes a vision discount benefit through Vision Service Plan (VSP). The vision plan includes examinations at discounted fees and the purchase of eyeglasses, sunglasses and other prescription eyewear at reduced prices when provided by participating Vision Service Plan providers.

Laser VisionCare is offered at a discount and is available through VSP contracted laser centers.

To access benefits, choose any plan provider from the Vision Service Plan list of providers to schedule an appointment. **To locate the VSP contracted provider closest to you, check the VSP website at www.vsp.com. Always take your Assurant dental/vision plan membership ID card with you.**

You will receive instant savings on eye exams and contact lens exams as well as frames, lenses, lens add-ons, and prescription sun glasses.

There are no claim forms or reimbursement checks. You pay the plan provider the reduced plan fees at the time of service. This plan is NOT insurance.

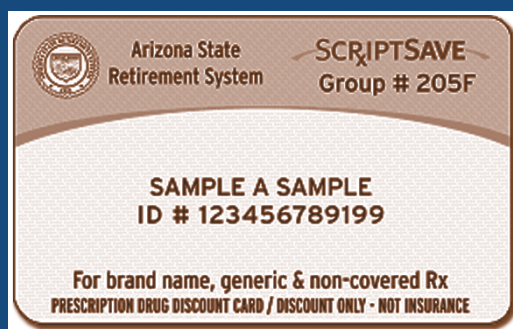
To receive a VSP provider directory or if you have questions please contact Vision Service Plan at 1-800-877-7195.





With ScriptSave, you will receive:

- Average savings of 21%, with potential savings of up to 50%.*
- Access to over 52,000 participating pharmacies nationwide, including both chain and independent retail pharmacies.
- Instant savings at the time of purchase; with no forms to fill out or paperwork to complete.
- Easy to use with no limits on usage for both brand and generic prescriptions.



(800) 700-3957
www.scriptsav.com

You and your family can receive valuable savings on your prescriptions by using the ScriptSaveSM Prescription Drug Savings Card!

ASRS is pleased to continue to offer prescription savings to retirees through ScriptSave, an Arizona-based prescription savings program. Since 2001, when ASRS began providing the ScriptSave card, retirees have saved over \$1.7 million on their prescriptions!

Best of all, the ASRS provides you with a ScriptSave card at **NO COST** and you will receive a card even if you do not have a medical insurance plan with the ASRS.

The ScriptSave card also works for you whether or not you enroll in a Medicare Part D plan.

Members enrolled in an ASRS Medicare eligible medical plan already have an equivalent Medicare Part D prescription drug plan as part of their medical plan. So, there is no need to enroll in a separate Medicare Part D plan.

As a ScriptSave cardholder, you can also receive access to free health and wellness information, as well as valuable savings and coupons on both prescription and over-the-counter medications.

Additionally, ScriptSave's Value Preferred Program may save you even more. ScriptSave has identified a selection of medications that may offer additional savings and has created a Value Preferred Medications List you can discuss with your healthcare provider.

Sign Up and Start Saving Today!

Step 1:

Visit www.scriptsav.com

Step 2:

Go to the Card Services page, click on the option to enroll & log-in using Group #869.

Step 3:

Print out your card & take it to the pharmacy the next time you or your family member fills a prescription.

If you have lost or misplaced your ScriptSave card, or have any questions about your card, please call ScriptSave Customer Care at 1-800-700-3957, weekdays from 9am to 7pm EST. Or, to find the participating pharmacy closest to you, visit ScriptSave's website: www.scriptsav.com.

** Based on national program savings data.*

DISCOUNT ONLY – NOT INSURANCE. This program is not an insurance policy and does not provide insurance coverage. Discounts are available exclusively through participating pharmacies.



Enroll in the **SilverSneakers® Fitness Program** to help promote better health and maintain your independence. SilverSneakers is **available at no additional cost** for all Arizona State Retirement System retired members and dependents enrolled in ASRS medical plan!

The SilverSneakers Fitness Program

As the nation's leading exercise program designed exclusively for older adults, SilverSneakers includes a basic membership (*see list on next page*), specialized SilverSneakers classes, Senior AdvisorSM assistance and much more!

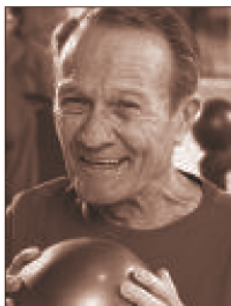
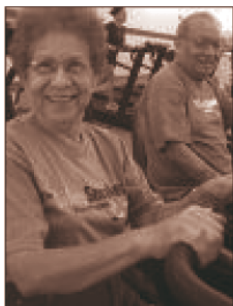
SilverSneakers Steps

If you live outside the areas listed for the SilverSneakers Fitness Program, increase your physical activity by joining **SilverSneakers® Steps**, a self-directed, pedometer-based walking and exercise program.

Prime

Non-Medicare ASRS members age 50 to 64 can participate in this innovative, exciting program that will help you manage your health and well-being at no additional cost. Visit our website, www.primemember.com, for more information.

For more information about SilverSneakers or SilverSneakers Steps, log on to www.silversneakers.com.



*SilverSneakers is the best thing to come along.
I can't think of enough good things to say
about your program!*

LaVerne Walsh, ASRS member, Tucson, AZ

Get Fit, Have Fun, Make Friends!

Activate your membership today at any participating location!

Ahwatukee/Foothills
Ahwatukee Foothills YMCA
 1030 E. Liberty Ln.
 480-759-6762
 Amenities: E, P, SC

Apache Junction
Apache Junction
Multigenerational Center
 1035 N. Idaho Rd.
 480-474-5240
 Amenities: E, SC

Bullhead City
Mad Dog Fitness
 2350 Miracle Mile Dr., Ste. 370
 928-704-7717
 Amenities: E, SC

Casa Grande
Casa Grande Fitness & Racquet Club
 2080 N. Trekell Rd.
 520-836-0613
 Amenities: E, S, W, SC

Chandler
Chandler-Gilbert Community College - Pecos Campus
 2626 E. Pecos Rd.
 480-732-7200
 Amenities: E, SC

Fitness Forum
 2130 W. Chandler Blvd.
 480-812-0200
 Amenities: E, S, P, W, SC

Cottonwood
Valley Athletic Club
 904 N. Main St.
 928-634-9886
 Amenities: E, S, SC

Flagstaff
Flagstaff Athletic Club
 3200 N. Country Club Dr.
 928-526-8652
 Amenities: E, S, P, W, SC

Fountain Hills
Anytime Fitness - Fountain Hills
 16650 E. Palisades Blvd., Ste. 109
 480-837-5151
 Amenities: E, SC

Gilbert
Fitness Works - Gilbert
 1668 N. Higley Rd.
 480-396-0086
 Amenities: E, S, P, W, SC

Glendale
Glendale Community College Fitness Center
 6000 W. Olive Ave.
 623-845-3801
 Amenities: E, P*, SC

Glendale/Peoria YMCA
 14711 N. 59th Ave.
 602-588-9622
 Amenities: E, P, SC

Goodyear
Infinity Fitness Center
 255 N. Litchfield Rd.
 623-882-3700
 Amenities: E, SC

Southwest Valley Regional YMCA
 2919 N. Litchfield Rd.
 623-935-5193
 Amenities: E, P, SC

Green Valley
Independent Lifestyle Fitness Center
 630 W. Ward Lane, Ste. 132 & 142
 520-625-9649
 Amenities: SC

Lake Havasu City
London Bridge Racquet & Fitness Club
 1407 McCulloch Blvd.
 928-855-6274
 Amenities: E, S, P, W, SC

Maricopa
Anytime Fitness - Maricopa
 20924 N. John Wayne Pkwy.
 Ste. D-4
 520-568-5226
 Amenities: E, SC

Mesa
Bally Total Fitness - Mesa
 1350 S. Longmore Rd.
 480-844-7227
 Amenities: E, SC

Fitness Works
 6040 E. Brown Rd.
 480-807-5080
 Amenities: E, S, P, W, SC

Mesa Family YMCA
 207 N. Mesa Dr.
 480-969-8166
 Amenities: E, P, SC

Mesa (cont.)
Pure Fitness - Mesa
 931 S. Gilbert Rd.
 480-497-9989
 Amenities: E, S, P, W, SC

Red Mountain
Multigenerational Center
 7550 E. Adobe
 480-644-4810
 Amenities: E, SC

Nogales
Fitness Express
 2051 N. Grand Ave.
 520-761-4820
 Amenities: E, SC

Payson
Payson Athletic Club
 400 E. Hwy. 260 Ste. F
 928-474-0916
 Amenities: E, SC

Peoria
Fitness One
 9028 W. Union Hills Dr., Ste. 1
 623-376-7888
 Amenities: E, SC

Phoenix
Bally Total Fitness - Cave Creek
 12235 N. Cave Creek Rd.
 602-482-1151
 Amenities: E, S, P, W, SC

Bally Total Fitness - Indian School
 3921 E. Indian School Rd.
 602-956-4116
 Amenities: E, SC

Chris-Town YMCA
 5517 N. 17th Ave.
 602-242-7717
 Amenities: E, P, SC

Fitness West
 6850 W. Indian School Rd.
 623-846-6884
 Amenities: E, S, P, W, SC

Lincoln Family Phoenix Downtown YMCA
 350 N. 1st Ave.
 602-257-5138
 Amenities: E, S, P, W, SC

Locations are subject to change. Log on to www.silversneakers.com for current listing.

Phoenix (cont.)

Paradise Valley Community College Fitness Center
18401 N. 32nd St.
602-787-7270
Amenities: E, SC

Phantom Horse Athletic Club
7777 S. Pointe Pkwy.
602-431-6484
Amenities: E, S, P, W, SC

Phoenix College Fitness Center
1202 W. Thomas Rd.
602-285-7646
Amenities: E, SC

South Mountain YMCA
222 E. Olympic Dr.
602-276-4246
Amenities: E, P, SC

The Family Life Center
5757 N. Central Ave.
602-707-5903
Amenities: E, S, SC
Located on the campus of North Phoenix Baptist Church

Prescott

Prescott Downtown Athletic Club
130 N. Cortez
928-445-0204
Amenities: E, S, W, SC

Prescott Valley Anytime Fitness - Prescott Valley
6715 E. 2nd St., Ste. A
928-443-5701
Amenities: E, SC

Queen Creek

Copper Basin YMCA
28300 N. Main St.
480-882-2242
Amenities: E, P, W, SC

Scottsdale

Fitness Experience
10155 E. Via Linda
480-451-7650
Amenities: E, S, SC

Scottsdale Community College Fitness Center
9000 E. Chaparral Rd.
480-423-6604
Amenities: E, SC

Scottsdale/Paradise Valley YMCA
6869 E. Shea Blvd.
480-951-9622
Amenities: E, P, SC

Sedona

Sedona Community Center
2615 Melody Ln.
928-282-2834
Amenities: SC

Sierra Vista

Cochise Health & Racquet Club
4225 Avenida Cochise
520-458-7075
Amenities: E, S, P*, W, SC

Sun Lakes

MaxLife
24210 S. Oakwood Blvd.
480-802-6853
Amenities: E, S, P, W, SC

Surprise

Fitness One
16630 W. Greenway Rd., Ste. 307
623-594-4887
Amenities: E, SC

Fitness One

12851 W. Bell Rd., Ste. 22
623-977-7588
Amenities: E, SC

Tempe

Tempe Northside Multi-generational Center
1555 N. Bridalwreath St.
480-858-6500
Amenities: SC

Tempe YMCA

7070 S. Rural Rd.
480-730-0240
Amenities: E, P, W, SC

Tucson

Arizona Swim and Fitness
1290 W. Prince
520-408-2888
Amenities: E, S, P, W, SC

Bally Total Fitness - Tucson

4690 N. Oracle Rd. #100
520-293-2330
Amenities: E, P, W, SC

Desert Sports & Fitness

3672 S. 16th Ave.
520-791-7799
Amenities: E, SC

Desert Sports & Fitness

2480 N. Pantano Rd.
520-722-6300
Amenities: E, S, P, W, SC

FIT at the River

4892 N. Stone Ave., Ste. 160
520-690-9299
Amenities: E, SC

Tucson (cont.)

FitCenter
5555 E. 5th St.
520-571-7000
Amenities: E, S, P, W, SC

Gold's Gym Northwest

7315 N. Oracle Rd.
520-297-8000
Amenities: E, S, P, W, SC

Highlands Mobile Home

Estate Clubhouse
332 W. Matterhorn
520-297-2722
Amenities: SC

Lighthouse/City YMCA

2900 N. Columbus Blvd.
520-795-9725
Amenities: E, P, W, SC

Lohse Family YMCA

60 W. Alameda St.
520-623-5200
Amenities: E, S, P, W, SC

Mid-Valley Athletic Club

140 S. Tucson Blvd.
520-792-3654
Amenities: E, S, P, W, SC

Northwest Family YMCA

7770 N. Shannon Rd.
520-229-9001
Amenities: E, P, SC

Ott Family YMCA

401 S. Prudence
520-885-2317
Amenities: E, P, W, SC

Tucson Jewish Community Center

3800 E. River Rd.
520-299-3000
Amenities: E, S, P, W, SC

Yuma

Yuma Family YMCA
2550 S. 4th Ave.
928-317-0522
Amenities: E, SC

Amenities Legend

E	Exercise Equipment
S	Steam/Sauna
P	Pool
W	Whirlpool
SC	SilverSneakers Classes
*	Seasonal Pool

PacifiCare Wellness and Disease Management Programs

Preventive Health Management

PacifiCare has designed preventive health services to help maintain the well being of members who are basically healthy. These include educational and screening guidelines and programs available through members' primary care physicians and health-related information and programs accessible on our Internet site at www.pacificare.com. It also includes some direct mail reminder programs for healthy members who appear to be missing recommended periodic preventive health screenings.

- **Taking Charge of Diabetes**
Focuses on self-care and lifestyle management
- **Taking Charge of Asthma**
Supports members & children in the daily management of symptoms via educational materials and tools
- **Taking Charge of Your Heart Health**
Focuses on behavior modification and includes reminders to have preventive care exams and tests on a routine basis
- **Taking Charge of Depression**
Complements care received from the member's physician

As part of PacifiCare's total solution strategy to address health care costs both short-term and long-term, numerous programs are available. These programs are accessible via our website at www.pacificare.com.

- **Nurse/Health Information**
24-Hour Phone Line
- **PacifiCare Perks**
Offering discounts on alternative care and other services

- **Health Risk Assessment**
Self-completed program to aid member in identifying disease risks and how to address each of these
- **Women's Health Solutions**
Special educational programs designed for women who make 80% of healthcare decisions
- **Latino Health Solutions**
Designed to meet the diversity of the workplace with special website and language tools

Acute Episode Management

PacifiCare members are assured of receiving all the appropriate care at the right time and place. Sooner or later, nearly everyone faces a need for care in a hospital or other acute care facility.

- **Precertification Processes for Elective Surgery**
Select procedures chosen to precertify, utilizing nationally recognized standards from MillimanUSA
- **Hospitalists in Each Hospital**
Specially trained hospitalists available 24/7 for all admissions to coordinate hospital care and post-hospitalization plans
- **Concurrent Review & Discharge Specialist RNs**
PacifiCare nurse to assist in documenting level of care and assisting hospital physicians/nurses to coordinate plans
- **Pharmacy Management, Available Medications**
Appropriate medications available for treating all conditions

PacifiCare Wellness and Disease Management Programs

Chronic Disease Management

PacifiCare is committed to improving the quality of care received by our members with chronic diseases. Programs are managed through special contracts with select, experienced national companies in all PacifiCare states.

- **ESRD (Renal Failure)**
A core program in place for members with severe renal failure and/or undergoing dialysis
- **CHF (Heart Failure)**
A core program in place for members with heart failure
- **Oncology (Cancer)**
A core program in place for members with cancer
- **Orthopedic Surgery**
A core program to identify hospitalized members with Orthopedic surgery to assist in managing them to optimal recovery

Wellness Program

PacifiCare has taken a proactive approach to improve the health status of ASRS members. Please see page 49 for more details on the *SilverSneakers* and *Prime* programs.

Special Care Programs

Meeting the needs of the ASRS requires flexibility and dedicated resources. Towards this end, PacifiCare will continue to be proactive in the area of Special Care. Management programs include:

- **Transplant Management**
Centers of Excellence around the U.S. are in place to handle all PacifiCare members for all solid organ and bone marrow transplants. Facilities are selected based on outcomes and convenience. All travel/ lodging is covered for members and nearest of kin.
- **Complex Case Management**
For members who need assistance to coordinate care among diverse specialists with unique diseases.
- **Frail Member Care Management**
This comprises several specially designed population programs to enhance members' quality of life and maintain their functional independence. These programs may include social services, case management and other programs.

PacifiCare Allies Health Discount Program

PacifiCare's Secure Horizons Medicare Complete Plan members receive the UnitedHealth discount program. As a member you can save on health care purchases that are not part of your benefit plan or any supplemental plan(s) you may have purchased. You will receive savings from a network of health care professionals, facilities, and online shopping partners. Typical savings range from 5-50 percent based on the program and service(s) provided.

Programs Offered:

- Lasik • Cosmetic Dental • Alternative Care
- Wellness • Long-term Care Services • Hearing

Remember...

- The health discount program is not insurance.
- Always use your health insurance for covered health services under your plan.
- Some specialties are not available in all areas.
- Please log on to the website or call Customer Care for the latest program descriptions & savings.
- Typical savings statements are estimates only.
- Your spouse and dependents living with you, as well as children away at school, can also use the health discount program to save.

This is a summary of the Allies Health Discount Program. To use the discount program and/or to obtain additional information please go to www.medsavings.unitedhealthallies.com or call Customer Care Center at 888-212-9095.



Are you a caregiver?

Do you care for a loved one or does someone care for you?

- ✓ Do you help your spouse or need help with daily tasks such as bathing, dressing or taking medication?
- ✓ Do you help your parent get to and from the drugstore or doctor's office?
- ✓ Are you concerned that your loved one or you may not be able to remain independent?
- ✓ Do you feel overwhelmed, alone and don't know where to turn for help?

If you are one of 44 million Americans who is a caregiver or if someone is caring for you, Evercare™ Solutions for Caregivers can help. To learn more about our personalized approach to caregiving and how it may benefit you and your loved one, read on.



How Can Solutions for Caregivers Help Me?

You've been looking forward to a carefree retirement, but instead you've taken on a new and even more demanding job – caring for a spouse or loved one. Thanks to **Solutions for Caregivers**, there's help. This ground-breaking program is available to you through your former employer's group retiree program with Evercare, a division of UnitedHealth Group.



In-Person Professional Care Manager Services

- Up to six hours of Professional Care Management, through a contracted nationwide network, per eligibility year.
- Personalized in-home assessment along with a comprehensive plan of care available to you and your spouse or other adult loved one.
- Help finding and coordinating local support services that meet the needs of both the caregiver and aging loved one.
- Review of alternate living accommodations plus move coordination when necessary.



Elder Law Referral and Services

- Access to contracted nationwide network of Elder Law attorneys for you, your spouse or other aging loved one under your care.
- Up to two cost-free hours of consultation on four Elder Law topics per eligibility year.
- Cost-free preparation of four Simple Wills and four Living Wills related per eligibility year.
- Consultation and preparation (if needed) of up to four of the following documents (for a \$35 per document fee paid directly to the attorney) per eligibility year.
 - Durable Power of Attorney
 - Financial Durable Power of Attorney
 - Health Care Durable Power of Attorney
 - Health Care Directive



Unlimited Telephonic Support

- Provide centralized toll-free telephonic support 24 hours a day, 7 days a week.
- Conduct timesaving, personalized research by identifying local resources and services that fit your caregiving needs.
- Coach you on how to deal with family issues and the stress of caregiving.

www.EvercareHealthPlans.com/Caregiver

Evercare® plans are offered by United HealthCare Insurance Company, or one or more of its affiliated companies (including PacifiCare and Oxford licensed HMOs and insurance companies).

Help is just a phone call away.
1-866-896-1895

How to Complete Your 2009 Enrollment Form

If you are enrolled in the MedicareComplete HMO plan, Senior Supplement Plan, the non-Medicare HMO, PPO or the Indemnity plans, your current ASRS benefit elections will automatically carry forward to 2009, unless you make a change in plan coverage. If you need or want to make a change, you must complete an enrollment form if you want to be covered by the ASRS retiree health care plans. Submission of a properly completed enrollment form is required if you:

- are electing a different medical plan,
- are electing a different dental plan,
- are adding dependents,
- are a new enrollee with the ASRS,
- become Medicare eligible in January, 2009, or
- move your primary residence which would cause a change in health care plan eligibility.

Section 1

- Effective date should be January 1, 2009.
- If you do not want ASRS medical coverage, check Decline Medical Coverage.
- If you do not want ASRS dental coverage, check Decline Dental Coverage.
- Check the box that applies: Retired, Disabled or Survivor.

Section 2

- This is the section to provide your name, social security number, address, etc.

Section 3

- If you are enrolling, indicate which Medical Insurance Plan you are electing.

Section 4

- If you are enrolling, indicate which Dental Insurance Plan you are electing.
- Prepaid Dental Plan only—include Dentist ID# from Assurant Provider Directory.
- If you are unsure what to include, please contact Assurant Employee Benefits at 1-800-443-2995.

Section 5

- List yourself and all other eligible individuals you are including as dependents.
- For HMO and MedicareComplete Plan only—indicate the names of the Primary Care Physician and Network you are choosing. These are listed in the PacifiCare Provider Directories. If you are unsure what to list, please contact PacifiCare at 1-800-347-8600, or SecureHorizons at 1-866-622-8055.

Section 6

- Sign and date the form and return it by the **November 14, 2008** deadline.
- **KEEP THE GOLDENROD COPY FOR YOUR RECORDS.**

Statement of Understanding (SOU)

The SOU must be completed by all retirees and/or dependents who have Medicare Parts A & B who are enrolling in the MedicareComplete Plan. UnitedHealthcare has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the management of Medicare, to provide comprehensive health services to persons enrolled in the MedicareComplete Plan.

By signing the SOU, the retiree and/or dependent indicates to UnitedHealthcare and CMS that you understand:

- You must maintain Parts A & B by continuing to pay the Part B premiums and the Part A premiums, if applicable. These premiums are deducted from your Social Security check and **not** from your ASRS pension check.
- All medical services, with the exception of emergency services, urgently needed services, out-of-area dialysis and routine travel dialysis, or services for which the Plan allows members to self-refer to contracting providers, must be provided or arranged by the Plan-contracted providers. Services rendered without prior-authorization from MedicareComplete® Plan, with the exception of emergency

services, urgently needed services, out-of-area renal dialysis and routine travel dialysis, or services for which MedicareComplete® Plan allows member to self-refer to contracting providers, will not be reimbursed by the Plan or Medicare.

- You are bound by the benefits, co-payments, exclusions, limitations and other terms of the PacifiCare Evidence of Coverage.
- You can only be enrolled in one MedicareComplete or Senior Supplement Plan at any one time.
- Your effective date of coverage will be the first day of the month following the date that PacifiCare receives the completed enrollment form and SOU, and verification of Medicare Parts A and B, unless the requested effective date is at a later date.

If you are enrolling in the Medicare Complete Plan for the first time, your completed SOU must be submitted along with your enrollment form to the ASRS (or PSPRS, if applicable). UnitedHealthcare will also verify your enrollment in Medicare Parts A and B.

- Keep the goldenrod copy of the Enrollment Form for your records.

Cost for Coverage *Medical Plan Premiums*

REVISED OCT 7, 2008

Corrects omission found on this page in the 2009 Open Enrollment Guide.

(January 1 through December 31, 2009)

Use this chart to determine how your medical plan election will affect your pension check.

MONTHLY PREMIUMS – MEDICAL PLANS PROVIDED BY PACIFICARE OF ARIZONA

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
PacifiCare® <small>A UnitedHealthcare Company</small>	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependent(s) One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without

Maricopa, Pima and Pinal Counties

HMO	\$454.00	\$908.00			Please see next page for combination premiums.
PPO	\$600.00	\$1200.00			
Senior Supplement ⁽³⁾ w/PDP			\$342.00	\$684.00 ⁽²⁾	
MedicareComplete			\$145.00	\$290.00 ⁽²⁾	

La Paz, Yuma, Santa Cruz, Cochise, Graham, Greenlee, Coconino & Yavapai Counties

HMO—Limited Service Areas ⁽¹⁾	\$454.00	\$908.00			Please see next page for combination premiums.
PPO	\$420.00	\$840.00			
Senior Supplement ⁽³⁾ w/PDP			\$342.00	\$684.00 ⁽²⁾	
MedicareComplete			\$210.00	\$420.00 ⁽²⁾	

Mohave, Gila, Navajo and Apache Counties

HMO—Limited Service Areas ⁽¹⁾	\$454.00	\$908.00			Please see next page for combination premiums.
PPO	\$420.00	\$840.00			
Senior Supplement ⁽³⁾ w/PDP			\$342.00	\$684.00 ⁽²⁾	

Out-of-State

Indemnity	\$871.00	\$1742.00			Please see next page for combination premiums.
Senior Supplement ⁽³⁾ w/PDP			\$342.00	\$684.00 ⁽²⁾	

Notes applicable to Cost of Coverage

- (1) Available to rural Arizona residents but with restrictions. HMO service areas are Maricopa, Pima and Pinal counties. See question 8 on page 66 for further explanation.
- (2) Retiree and dependents monthly premium is a multiple of the number of lives covered and the Retiree Only premium. For example, the monthly premium for 3 eligible MedicareComplete Plan participants who have Medicare Parts A and B is \$435.00 (3 X \$145.00). Likewise, the monthly premium for 3 eligible Senior Supplement plan participants who have Medicare Parts A and B is \$1,026.00 (3 X \$342.00).

Cost for Coverage *Medical Plan Premiums*

(January 1 through December 31, 2009)

Use this chart to determine how your medical plan election will affect your pension check.

MONTHLY PREMIUMS – MEDICAL PLANS PROVIDED BY PACIFICARE OF ARIZONA

	COMBINATIONS	
PacifiCare® <small>A UnitedHealthcare Company</small>	Retiree & Dependents One with Medicare, the others without	Retiree & Dependent with Medicare, other dependents without

Maricopa, Pima and Pinal Counties

Senior Supplement (3) w/HMO	\$ 796.00	\$1138.00
Senior Supplement (3) w/PPO	\$ 942.00	\$1284.00
MedicareComplete w/HMO	\$ 599.00	\$ 744.00
MedicareComplete w/PPO	\$ 745.00	\$ 890.00

La Paz, Yuma, Santa Cruz, Cochise, Graham, Greenlee, Coconino and Yavapai Counties

Senior Supplement (3) w/HMO (1)	\$ 796.00	\$1138.00
Senior Supplement (3) w/PPO	\$ 762.00	\$1104.00
MedicareComplete w/HMO (1)	\$ 664.00	\$ 874.00
MedicareComplete w/PPO	\$ 630.00	\$ 840.00

Mohave, Gila, Navajo and Apache Counties

Senior Supplement (3) w/HMO (1)	\$ 796.00	\$1138.00
Senior Supplement (3) w/PPO	\$ 762.00	\$1104.00

Out-of-State

Senior Supplement (3) w/Indemnity	\$1213.00	\$1555.00
-----------------------------------	-----------	-----------

Notes applicable to Cost of Coverage

- (3) The Senior Supplement medical plan includes a Medicare Part D prescription drug plan (PDP). If you are currently enrolled in the Senior Supplement medical plan and you elect to cancel your medical plan coverage, you are also canceling your Medicare Part D prescription drug coverage.


NOTE: Residency in a non-service area is required by Arizona Revised Statutes § 38-783 in order to receive the rural subsidy, and that the ASRS reserves the right to request documentation to confirm eligibility status. Any person who knowingly makes any false statement with an intent to defraud the ASRS is guilty of a Class 6 felony in accordance with ARS §38-793.

Cost for Coverage *Dental Plan Premiums*

(January 1 through December 31, 2009)

Use this chart to determine how your dental plan election will affect your pension check.

MONTHLY PREMIUMS – DENTAL PLANS PROVIDED BY ASSURANT EMPLOYEE BENEFITS

 DENTAL INSURANCE PLANS	Retiree Only	Retiree & 1 Dependent	Retiree & 2 or more Dependents
Freedom Advance (High Option)	\$36.61	\$73.06	\$103.39
Freedom Basic (Low Option)	\$17.18	\$36.34	\$66.54
Prepaid (Arizona)	\$10.61	\$17.41	\$26.90
Prepaid (Other States Where Available)	\$10.45	\$17.64	\$27.87

Calculating Your Monthly Health Insurance Cost

Each retiree's circumstances are different. The ASRS offers retiree health insurance plans as does the Arizona Department of Administration and more than 200 participating employers to allow retirees to remain on their active employee coverage. Premium benefits for the basic and rural programs also vary depending on a retiree's years of service. They also vary among the four state retirement systems and plans. Premiums also differ depending on the plan in which the retiree is enrolled and whether single or family coverage is elected.

Use the worksheet on the next page to determine the applicable amounts of insurance premium

that either will be deducted from your monthly pension check or will be required to be paid directly to the insurance carrier(s) or to your employer.

Your ASRS retirement benefit check stub displays the basic premium benefit (PREM BEN), the rural subsidy (NONS RV PB) if applicable, and the full amount of your health insurance premium (TOT PREM). However, only your **net health insurance cost** is being deducted from your pension check. Please see pages 63-64 for a further explanation.

Net Monthly Health Insurance Cost Worksheet

Your monthly medical plan premium
from page 56-57.

A

Your monthly dental plan
premium from page 58.

+

B

Total Premium

(A plus B)

C

Your Basic Premium Benefit
(See chart on page 60).

—

D

Your Net Premium

(C minus D)

=

E

If you live in **Mohave, Gila, Navajo or Apache counties**, are Medicare eligible,
and are not eligible to enroll in an HMO,
please continue with the calculation.

Required Minimum HB2311 Payment
(See Required Payment chart on page 61).

—

F

**Net Premium before
Rural Subsidy**

(E minus F)

=

G

Rural Health Insurance Subsidy
(See Subsidy chart on page 62).

—

H

Your remaining out-of-pocket cost
(If H is greater than G, I will equal \$0.00)

=

I

(G minus H)

FOR SOME RETIREES, the total amount of premium owed will be box E, or a combination of boxes F and I, and for others, only box F.

Retiree Health Insurance Premium Benefit Program

Basic Premium Benefit Amounts

The monthly premiums shown in the charts on pages 56-58 are the full cost for the medical and dental coverages. The Arizona State Retirement System, Public Safety Personnel Retirement System, Elected Officials' Retirement Plan, and Corrections Officer Retirement Plan will provide payment toward insurance premiums for eligible members and their dependents. The chart below reflects the maximum monthly basic premium benefit available for eligible members and their dependents.

No basic premium benefit is provided to retirees in the University Optional Retirement Plans.

To determine your basic premium benefit, you need to know your years of credited service in your retirement system or plan; your coverage type, i.e., single or family coverage; and, whether you and covered family members are eligible for Medicare.

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	\$75.00	\$130.00	\$50.00	\$85.00	\$107.50	\$107.50
6.0–6.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
7.0–7.9	\$105.00	\$182.00	\$70.00	\$119.00	\$150.50	\$150.50
8.0–8.9	\$120.00	\$208.00	\$80.00	\$136.00	\$172.00	\$172.00
9.0–9.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
10.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
6.0–6.9	\$112.50	\$195.00	\$75.00	\$127.50	\$161.25	\$161.25
7.0–7.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
8.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Corrections Officer Retirement Plan (CORP) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Public Safety Personnel Retirement System (PSPRS) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00

Additional Temporary Premium Benefit Amounts

Rural Subsidy

Qualified Medicare eligible retirees **who are participating in a medical plan** provided by the ASRS, ADOA, or a participating employer of a state retirement system or plan and who live in areas of Arizona where no managed care (HMO) program

is offered (“non-service areas”) are entitled to receive an additional temporary premium benefit. The Rural Subsidy amounts shown below are **effective from July 1, 2007 through June 30, 2009**.

HB 2311 Required Payment – Eligible “rural” retirees are required to pay a portion of the cost of their medical insurance plan before the Rural Subsidy is applied to their remaining medical plan premium. Those amounts are:

Required Payment	
Medicare Eligible Retiree Only	\$100 per month
Medicare Eligible Retiree + Dependent(s)	\$200 per month
Medicare Eligible Retiree + Dependent(s) (Combination Plan)	\$400 per month
You are eligible for the Rural Subsidy if you satisfy all of the following:	
<ul style="list-style-type: none"> • are Medicare eligible; • live in Mohave, Gila, Navajo or Apache Counties; • are not eligible to enroll in an HMO plan from a participating employer or the ASRS; and, • are not a retiree of the University Optional Retirement Plans. 	

NOTE: Residency in a non-service area is required by Arizona Revised Statutes § 38-783 in order to receive the rural subsidy, and that the ASRS reserves the right to request documentation to confirm eligibility status. Any person who knowingly makes any false statement with an intent to defraud the ASRS is guilty of a Class 6 felony in accordance with ARS §38-793.

Additional Temporary Premium Benefit Amounts

Rural Subsidy

	WITH MEDICARE A & B		COMBINATIONS
Monthly Rural Subsidy Effective July 1, 2007 through June 30, 2009			Medicare Eligible Retiree with at least one Non-Medicare Dependent
Years of Service	Retiree Only	Retiree & Dependents	
Arizona State Retirement System (ASRS) Members			
5.0–5.9	\$85.00	\$175.00	\$235.00
6.0–6.9	\$102.00	\$210.00	\$282.00
7.0–7.9	\$119.00	\$245.00	\$329.00
8.0–8.9	\$136.00	\$280.00	\$376.00
9.0–9.9	\$153.00	\$315.00	\$423.00
10.0+	\$170.00	\$350.00	\$470.00
Elected Officials' Retirement Plan (EORP) Members			
5.0–5.9	\$102.00	\$210.00	\$282.00
6.0–6.9	\$127.50	\$262.50	\$352.50
7.0–7.9	\$153.00	\$315.00	\$423.00
8.0+	\$170.00	\$350.00	\$470.00
Corrections Officer Retirement Plan (CORP) Members			
not applicable	\$170.00	\$350.00	\$470.00
Public Safety Personnel Retirement System (PSPRS) Members			
not applicable	\$170.00	\$350.00	\$470.00

NOTE: Residency in a non-service area is required by Arizona Revised Statutes § 38-783 in order to receive the rural subsidy, and that the ASRS reserves the right to request documentation to confirm eligibility status. Any person who knowingly makes any false statement with an intent to defraud the ASRS is guilty of a Class 6 felony in accordance with ARS §38-793.

Pension Checks

If you have enrolled in ASRS or ADOA retiree health care coverage, don't forget to verify your January 1, 2009 pension check for the correct premium for the coverage(s) you elected. If you feel that your pension check is not accurate, you must notify

ASRS or, if applicable, PSPRS Member Services within 30 days of your January 1, 2009 pension check. **Changes or additions requested beyond 30 days will only be allowed if there is a Qualifying Event (see page 13).**

Your Pension Check, Health Insurance Premiums & Premium Benefits

If you are an ASRS retiree with ASRS or ADOA retiree health care coverage, you may believe that the ASRS is charging the full cost of health insurance because your pension check Payment Summary shows the full cost of health care plan premiums under the "Deductions" column.

However, under the "Payments" column of your pension check Payment Summary, please note the inclusion of additional monies reflected in the PREM BEN

(basic premium benefit) and, if applicable, NONSRVPB (non-service area premium benefit or rural subsidy). These two amounts are the premium benefits to which you may be entitled and they offset or reduce the full monthly medical and/or dental premiums you pay.

Though the total premium for health insurance is shown **you are only paying the net premium after the premium benefit(s) is applied.**

However, retirees are only paying the net premium after the premium benefit is applied.

64

Frequently Asked Questions

1. *If I don't enroll by the November 14, 2008 deadline, what will happen?*

If you wish, or are required, to make a plan change and you fail to submit your completed Enrollment Form by the close date, your election(s) will not become effective. Consequently, **you will not have the coverage you wanted and needed** beginning January 1, 2009.

2. *Can't I just enroll in the medical plan (or dental plan) I want on the Enrollment Form without having to complete the dental plan (or medical) portion because I'm not changing that coverage?*

Please read this! Complete the Enrollment Form in its entirety. Even if you are only changing from one medical plan to another medical plan or from one dental plan to another dental plan, fill out the form completely. Be thorough. If, in fact, you are declining coverage for 2009, please check the appropriate box(es) at the top of the Enrollment Form OR write a letter indicating your declining coverages. A properly completed Enrollment Form must be received by the ASRS or, if applicable, PSPRS, or be postmarked no later than midnight, Friday, November 14, 2008.

3. *Do I qualify for the temporary "non-service area" premium benefit?*

Determination of eligibility for the temporary, additional premium benefit requires that an enrolled Medicare eligible retired member reside in an area within this state in which a health maintenance organization (HMO) does not provide a contracted physician network available to serve the medical needs of its subscribers. If your primary residence is in a "non-service area," then you and, possibly, your eligible enrolled

dependents, may be eligible for this additional premium benefit or rural subsidy. Under current legislation, this additional premium benefit is scheduled to expire on June 30, 2009. Please see pages 61-62 for more details.

4. *What is the best way to determine which medical plan is right for me?*

There's a lot to consider. The key is for you to look at your own situation, study what the plans offer and their corresponding premiums, where the plans offer coverage (i.e., in which AZ county or out-of-state), and decide what is best for you.

5. *Both my spouse and I are ASRS retirees. What are our enrollment options?*

The ASRS Premium Benefit Program provides the greater of 2 single premium benefits or 1 family premium benefit to each retiree. Such retirees can receive the greatest application of the premium benefit program with one retiree enrolling in a medical plan choosing family coverage and the other retiree enrolling in a dental plan choosing family coverage.

6. *My current coverage will continue to be provided by my Participating Employer. What do I need to do?*

Some employers do not permit retirees to continue health insurance coverage at retirement. Other employers allow retirees coverage for a specific period of time. Review with your Participating Employer continuing eligibility. If you continue health insurance with your employer, complete a health insurance application with them. It is important you know how long you may continue coverage with your Participating Employer.

Frequently Asked Questions

Once you drop your Participating Employer's health insurance coverage, you may not be eligible to return to their plan. (NOTE: You are eligible to enroll in ASRS health insurance at the time of retirement, during open enrollment, or if you have a qualifying event.)

7. *What should I do if my spouse has benefits through another employer?*

Coordinate your coverages. Study what your spouse has, then decide which ASRS retiree health insurance options provide you with the most appropriate overall coverage. It is usually best to pick coverage that compliments, not duplicates, the other coverage.

8. *What restrictions are applicable to non-Medicare eligible retirees and dependents who live in "rural" Arizona for enrollment in PacifiCare's non-Medicare HMO medical plan?*

Non-Medicare eligible retirees and dependents who live in "rural" Arizona may enroll in PacifiCare's Health Maintenance Organization (HMO) medical plan provided the member understands and agrees that:

- All medical services are rendered and received at an office or facility within the chosen HMO service area and designated or referred by the HMO, and
- All non-emergency and/or non-urgent travel, ambulatory and other expenses

incurred by the member from the residence area of the member to the designated office or facility designated or referred by the HMO are the responsibility of and at the expense of the member. These expenses will not be reimbursed by PacifiCare.

9. *I'm enrolling for family coverage in the HMO. May I select one Primary Care Physician (PCP) for my whole family?*

While you may select one PCP for your whole family, you may want to choose different PCPs for each family member. Each covered family member may have his or her own PCP. You will need to record a PCP for each covered family member, even if you all use the same one, on the Enrollment Form in the "listing of eligible individuals to be enrolled" section near the bottom of the form.

10. *If I am enrolled in PacifiCare's HMO Plan or in the MedicareComplete Plan, I must choose a Primary Care Physician (PCP). What kind of doctors are available from which to choose when selecting a PCP?*

Your medical plan PCP is responsible for coordinating all of your medical care, including referrals to specialists and obtaining necessary prior authorizations. PCPs are Family Practice, General Practice, Internal Medicine or Pediatric Physicians. Women may self-refer to an in-network OB/GYN.

Frequently Asked Questions

11. *How can I get a directory of PacifiCare providers?*

Contact PacifiCare at 800-347-8600 or access their website at www.pacificare.com. For SecureHorizons call 866-622-8055 or their website at www.securehorizons.com. Please specify the PPO or HMO provider directory you wish to receive. Please remember that a copy of a provider directory is only accurate as of the date it was printed. Updated directories are on-line. You may call the physician you wish to select to verify their participation and availability. Also, you may call PacifiCare or SecureHorizons to learn of physicians in your area who may be new to the network or who may be accepting new patients.

12. *I'm enrolling for family coverage in the Assurant Prepaid Dental Plan. May I select a General Dentist for my whole family?*

Prepaid Dental: While you may select one General Dentist for everyone, you may want to choose a different General Dentist for each family member. Each covered family member can have his or her own General Dentist.

13. *What kind of dentist may I choose when selecting a General Dentist?*

Prepaid Dental: With your Assurant prepaid dental plan, you need to select a General Dentist from the list of contracted providers. Simply choose a provider from the provider directory and list the dentist ID# on your Enrollment Form. To get a directory, please call the Assurant ASRS on-site representative at the number listed on the inside back cover of this guide or visit the Assurant Employee Benefits website at www.assurantemployeebenefits.com.

fits.com. Click on "Find a Dentist" and then select "Heritage Series".

Indemnity Dental: With your Assurant indemnity dental plan, you have complete freedom-of-choice in dental providers. You have access to any eligible licensed General Dentist or specialist in the United States. Assurant strongly suggests that whenever the cost of any recommended dental care exceeds \$300, a dental treatment plan be submitted for review before treatment begins. This pre-estimate of benefits will inform you of your out-of-pocket costs.

14. *How do I change my General Dentist?*

Prepaid Dental: Call Assurant at 1-800-443-2995 to change General Dentists. Requests must be received by the 20th day of the month to be effective the 1st day of the following month. Requests received after the 20th of the month will be effective on the 1st day of the 2nd month. Remember, if you would like to change your General Dentist, you must contact Assurant before making an appointment with your new General Dentist.

Indemnity Dental: The plan provides complete freedom-of-choice in providers. No selection is necessary.

15. *How do I use my General Dentist?*

Prepaid Dental: Your General Dentist is responsible for maintaining your dental health. Should you need a specialist (periodontics, endodontics, oral surgery, orthodontia), you may self-refer for dental care. You are encouraged to discuss all your dental health needs with your General Dentist. He/she will be happy to work with you to assure

Frequently Asked Questions

you understand your dental health needs. Assurant's provider directory lists all dental providers. The contracted providers are credentialed by Assurant provider relations staff to assure they meet corporate standards.

Indemnity Dental: You have access to dental care from any eligible licensed dentist or specialist in the United States. However, you may use Assurant's Dental Health Alliance (DHA) participating dentists to receive additional savings on all your dental treatment and services. Participating DHA dentists discount their fees up to 30% off of their usual and customary fees. Call 800-985-9895 or visit the Assurant website at www.assurantemployeebenefits.com to locate a participating DHA dentist near you.

16. *What is the procedure if I need to see a Specialist?*

Prepaid Dental: You do not need a referral from your General Dentist to see a participating dental specialist. Contracted dental specialists are listed in the Assurant provider directory alphabetically by city and specialty, e.g. (endodontics, oral surgery, periodontics) The contracted Speciality Benefit Amendment (SBA) specialist will charge you the specialty care copayments listed on your Schedule of Benefits. For services not listed on the Schedule of Benefits, the specialist will offer a 25% discount (15% for endodontic care) off their usual and customary charge (UCR). Benefits for specialty care are not available from non-contracted dentists. Orthodontic care is offered to adults and children at a 25% discount from the dentist's

UCR fee.

Indemnity Dental: You have access to dental care from any eligible licensed dentist or specialist in the United States. However, you may use Assurant's Dental Health Alliance (DHA) contracted providers to receive additional savings on all your dental treatment and services. Participating DHA dentists will discount their fees to a maximum of 20%.

Call 1-800-985-9895 or visit the Assurant special website at www.dha.com to locate a DHA contracted provider near you.

17. *How much and when do I have to pay for my dental visit?*

Prepaid Dental: You will be charged according to your Schedule of Benefits on the Prepaid Dental Plan. Please discuss all charges with your General Dentist before the services are performed. Payment for dental services is due at the time treatment is rendered. Dental services not listed on your Schedule of Benefits are NOT covered.

Indemnity Dental: Most dentists will file your dental claims for you and charge you your coinsurance and any deductible that may apply. You will receive an Explanation of Benefits after Assurant pays the claim which will show you what services have been covered and the amount for which you are responsible.

18. *What is an emergency/problem focused dental exam?*

It is a dental exam, other than an initial

Frequently Asked Questions

or periodic exam, which is limited to a specific oral health problem. An emergency/problem focused dental exam is the sudden and unexpected onset of an acute condition involving severe pain, requiring immediate dental care for temporary pain relief. For the prepaid plan only, dental appointments are on an availability only basis and at a \$25 copayment fee.

19. *How can I get a directory of Assurant dental providers?*

Prepaid Dental: Call 800-443-2995 or access the Assurant website at www.assurantemployeebenefits.com.

Indemnity Dental: You have access to dental care from any eligible licensed dentist or specialist in the United States. However, you may use Assurant's Dental Health Alliance (DHA) participating dentists to receive additional savings on all your dental treatment and services. Call 800-985-9895 or visit the Assurant website at www.assurantemployeebenefits.com to locate a participating DHA dentist near you.

20. *What should I tell my dependent beneficiary to do about my pension benefits and health insurance coverage in the event of my death?*

There is no quick or simple answer. Your dependent beneficiary is encouraged to contact ASRS Member Services, PSPRS Member Services Staff, or ADOA Member Services, if applicable, at the time of your death. Decisions will have to be made regarding continuation of pension benefits if you elected a pension option other than straight life annuity. Likewise, continuation of or enrollment in an ASRS retiree health care plan by your beneficiary must be decided within six (6) months of your death. An enroll-

ment form must be filled out by your beneficiary and/or dependent (who has medical and/or dental coverage on your policy) and mailed to ASRS. Also, if you elected a reduced premium benefit, your beneficiary may be entitled to a continuation of that benefit. Your beneficiary will need to provide certified copies of your death certificate to affect any change in your pension or health insurance benefits.

21. *How long may I cover my dependents on my health insurance plan(s)?*

You may provide coverage to your lawful spouse, domestic partner and unmarried children (natural born, legally adopted, placed for adoption, legal guardian status) who reside with you on a permanent basis and depend on you for support and maintenance.

Dependent children are covered through the end of the month of their 19th birthday unless they meet the student status criteria. An unmarried dependent who is registered on a full-time basis (at least twelve (12) semester units) at an accredited school or college may continue as an eligible dependent through the end of the month of their 25th birthday, if proof of such status continues and is provided on a periodic basis.

Coverage for disabled dependent children may continue provided the unmarried dependent lives with you, is incapable of self-sustaining employment by reason of physical handicap or mental limitation, is chiefly dependent on you for support and maintenance, and the mental or physical condition existed continuously prior to reaching the respective limiting age.

Frequently Asked Questions

22. *How much are the 2008 monthly premiums for Medicare Part "B"?*

Since January 1, 2007, your Part B premiums have been based on your income. Most people will pay the standard monthly Part B premium of \$96.40. Some people will pay a higher premium based on their modified adjusted gross income.

Your monthly premium will be higher if you file an individual tax return and your annual income is more than \$82,000, or if you are married (file a joint tax return) and your annual income is more than \$164,000.

If you meet these criteria, Social Security will use income from three years ago. For example, the income reported on your 2007 tax return will be used to determine your monthly Part B premium in 2009. If your income has decreased since 2005, you can ask that the income from a more recent

tax return be used to determine your premium, but you must meet certain criteria.

At the end of 2008, Social Security Administration should have sent to you a letter if your Part B premium will increase based on the level of your income and to tell you what you can do if you disagree. For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

The chart below shows 2008 Part B monthly premium amounts based on income. These amounts change every other year. There may be a late-enrollment penalty.

PLEASE NOTE: The Center for Medicare and Medicaid Services had not published the 2009 Part B premium schedule at the time of this printing.

You Pay:		If Your Yearly Income Is:	
\$96.40 \$122.20 \$160.90 \$199.70 \$238.40		SINGLE	MARRIED COUPLE
		\$82,000 or less	\$164,000 or less
		\$82,001 - \$102,000	\$164,001 - \$204,000
		\$102,001 - \$153,000	\$204,001 - \$306,000
		\$153,001 - \$205,000	\$306,001 - \$410,000
		Above \$205,000	Above \$410,000
You Pay:		If Married But Filing a Separate Tax Return, and Your Yearly Income Is:	
\$96.40 \$199.70 \$238.40		\$82,000 or less	
		\$82,001 - \$123,000	
		Above \$123,000	

Frequently Asked Questions

23. *I understand that there are pre-existing condition limitations in the ASRS retiree PPO medical plan. What does that mean?*

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this requirement pertains to pre-existing conditions, what constitutes a break in coverage, and the need to provide a certificate of coverage when enrolling in the ASRS retiree PPO medical plan.

If you enroll in the ASRS retiree PPO medical plan after January 1, 2005, you will be required to provide a **certificate of coverage** that indicates what current or prior coverage you have. **Your health care plan administrator must provide this form to you.** The certificate indicates the period of time you and/or your dependents were covered under your plan, the name of the plan, the termination date of your or your dependents' coverage, and the number of months of the plan's pre-existing condition limitation.

The purpose of the certificate is to reduce any exclusion for pre-existing conditions that may apply to you and/or your dependents upon enrolling in the ASRS retiree PPO medical plan.

A **pre-existing condition** is any illness or injury (whether physical or mental) regardless of its cause, for which medical advice, diagnosis, care, or treatment including prescription medications were recommended, received, or taken within the six (6) month period immediately preceding the date your ASRS coverage begins. If it is determined that you or any of your covered dependents have a pre-existing condition, no expenses

related to that pre-existing condition will be covered by the ASRS medical plan before twelve (12) consecutive months of coverage have elapsed.

You will receive credit from your prior coverage toward the ASRS pre-existing condition limitation if there is no **break in coverage** from your prior plan. In other words, if you come from your employer plan (in which you have satisfied that plan's pre-existing condition limitation) immediately to an ASRS medical plan, there is no break in coverage. However, if you have a break in coverage of 63 days or more, no credit will be allowed from participating in your prior plan.

It is always best to maintain health insurance coverage on you and your family.

Glossary

Allowable Amount Term used by some health care plans (both medical and dental plans) to determine the amount of the Billed Charge which would be considered Usual, Customary, and Reasonable (see page 72 for definition). Term may also be known as the allowable charge.

Balance Billing Billing a patient for the difference between the dentist's actual charge and the amount allowed or paid by the patient's dental benefits plan. Balance billing for an amount other than the discounted fee for the service(s) performed is not allowed with a DHA participating dentist.

Billed Charge The amount the provider bills for services rendered.

Coinsurance The percent of the allowable amount to be paid by the insurance company and the patient; i.e., 60/40 or 80/20. (The first percentage is paid by the company; 60 or 80.)

Copayment The fixed fee that must be paid to the provider at the time services are provided, such as the pharmacy for a prescription.

Deductible The initial amount the patient must pay out of their pocket for covered services before benefits are payable by the insurance carrier.

Emergency Defined by each plan in accordance with their standard definitions.

Health Maintenance Organization (HMO) A medical plan providing comprehensive medical benefits, including preventive care, when you agree to use a select group of network providers. Generally, all care is directed by your chosen Primary Care Physician (PCP). Your PCP will refer you to a specialist if medically appropriate.

Indemnity Dental Plan A dental plan that allows you to choose any eligible licensed provider in the United States to receive care. Members and dentists are reimbursed for eligible dental expenses according to the benefit schedule in effect, allowing for deductibles and coinsurance.

Indemnity Medical Plan A medical plan that allows you to choose any eligible licensed provider to receive care. Members are reimbursed for eligible medical expenses according to the benefit schedule in effect, allowing for deductibles and coinsurance.

In-Network Services provided by a contracted provider in accordance with all plan requirements.

Medicaid A state-run health insurance program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid.

Medicare Our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of Federal Insurance Contributions Act (FICA) taxes, or payroll taxes, paid by workers and their employers. It also is financed in part by monthly premiums paid by beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for managing both Medicare and Medicaid.

Glossary (continued)

There are three parts of Medicare. They are:

- **Hospital Insurance** (also called Medicare “Part A”), which helps pay for care in a hospital and skilled nursing facility, home health care and hospice care;
- **Medical Insurance** (also called Medicare “Part B”), which helps pay for doctors, out-patient hospital care and other medical services. Medicare requires that you pay a monthly premium for the Part B coverage.
- **Prescription Drug Insurance** (also called Medicare “Part D”), helps pay for a portion of the prescription drug expense after satisfying a calendar year deductible. Medicare requires that you pay a monthly premium for the Part “D” coverage. ASRS enrolled members do not have to purchase separate Part “D” coverage as each ASRS Medicare eligible medical plan provides a similar prescription drug program.

MedicareComplete Plan A health maintenance organization (HMO) plan authorized by the Centers for Medicare and Medicaid Services (CMS), the federal agency in charge of these programs, to become the member’s Medicare provider. Members must maintain Parts A and B of Medicare while enrolled in the MedicareComplete Plan. Generally, the plan provides prescription and other benefits beyond Medicare Parts A and B coverage.

Non-Participating Dental Provider A provider with no contractual limitation on what he/she may bill and thus may charge full fees for dental treatment and services performed.

Participating Dental Specialist A specialized provider, such as an endodontist, perio-

dontist, or oral surgeon, with a contractual limitation on what he/she may bill the patient for services covered by the prepaid dental plan.

Pre-Estimate of Benefits (Indemnity Dental plan only) Whenever the estimated cost of a recommended Dental Treatment Plan exceeds \$300, the treatment plan should be submitted to the insurance carrier for review. This permits the carrier to review the treatment plan for alternative treatment procedures, which may be less costly, provided they do not affect the quality of care. The member knows in advance what his/her financial responsibility for the treatment will be prior to the actual services being performed.

Preferred Provider A provider who has signed an agreement with the insurance carrier not to charge that carrier’s members more than the insurer’s Allowable Amount.

Precertification Review A process that verifies the medical necessity and appropriateness of proposed services or supplies.

Pre-Existing Condition is any illness or injury (whether physical or mental) regardless of its cause, for which medical advice, diagnosis, care, or treatment including prescription medications were recommended, received, or taken within the six (6) month period immediately preceding the date your ASRS coverage begins. If it is determined that you or any of your covered dependents have a pre-existing condition, no expenses related to that pre-existing condition will be covered by the ASRS medical plan before twelve (12) consecutive months of coverage have elapsed.

Preferred Provider Organization (PPO) Plan A plan that provides benefits in an

Glossary (continued)

indemnity fashion, but pays a higher percentage of the cost of services if patients use a PPO-network provider than if they use non-PPO providers. **If you go to a provider who is a member of the PPO network**, after you first satisfy a deductible, the plan generally pays 80 percent of the cost for care and you pay 20 percent. **If you go to a provider who is not a member of the PPO network**, after you first satisfy a deductible, the plan generally pays 60 percent of the cost for care and you pay 40 percent.

Prepaid Dental Plan A dental plan that allows reduced payment for dental services for members who agree to use dentists in the plan's provider network. Generally, dental care is provided through your chosen general dentist. Preventive services sought in accordance with the plan's schedule of benefits are generally provided at low cost to the member. Members pay according to a set schedule for restorative services. Certain major services may be provided by a specialized dentist at a higher cost to the member.

Primary Care Physician (PCP) The physician responsible in an HMO plan for directing all patient care including referrals to specialists and obtaining necessary pre-certifications. This physician is a General Practice, Family Practice, Pediatric or Internal Medicine specialist. Women can self-refer to an in-network OB/GYN.

Prophylaxis A routine cleaning procedure that includes light scraping (scaling) of the teeth to remove plaque and calculus/tartar. This procedure should be performed at least every six months.

Rehabilitation Usually physical therapy, speech therapy and/or occupational therapy.

Senior Supplement Plan is for members who are enrolled in both Medicare Parts A & B. With this Plan you have the freedom to obtain medical care from any physician or hospital that accepts Medicare.

MedicareComplete Disenrollment Form A form that must be completed and signed by all Medicare eligible retirees and/or dependents who are currently enrolled in a MedicareComplete Plan or the Senior Supplement Plan and who are dropping that coverage to return to traditional Medicare. This form requests that your health care coverage revert back to the traditional Medicare fee-for-service program. The effective date will be the first day of the month following receipt of the Disenrollment Form, unless a future date is requested.

Specialty Benefit Amendment A special amendment added to the pre-paid dental plan's Schedule of Benefits that allows patients to receive select major dental services from Assurant contracted specialists for a specific copayment, available to Arizona residents only.

Glossary (continued)

Statement of Understanding (SOU) If you are enrolling in the MedicareComplete Plan, you are required to sign and submit a Statement of Understanding along with your 2009 Enrollment Form. This is a federal government requirement mandated by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for these programs. The SOU summarizes the fundamental terms and conditions of your coverage.

For the MedicareComplete Plan, the SOU explains that, with the exception of emergency or out-of-area urgently needed care, services must be provided by your Primary Care Physician (PCP) or other

UnitedHealthcare contracted providers. If you receive services or treatments without precertification from UnitedHealthcare's contracted providers, the cost of those services or treatments would not be reimbursed by UnitedHealthcare or Medicare.

Usual, Customary and Reasonable (UCR)

A charge which is based on the general level of charges made by other providers in the area for like treatment, procedures, services, and or supplies, also known as the Allowable Amount or allowable charge. The insurance carrier's determination of the UCR is final for the purpose of determining benefits payable under the insurance carrier's policy.



Telephone Numbers & Websites

For Retirees, LTD Recipients, and Eligible Dependents

Remember when calling the insurance carriers, tell them you are an ASRS member.

Carrier	Member Services	Internet Address
Medical Provider		www.securehorizons.com
PacifiCare of Arizona (Weekdays 7am – 8pm MST)		www.pacificare.com
Spectera Vision	1-800-638-3120	www.spectera.com
HMO Plan	1-800-347-8600	
PPO Plan	1-866-316-9776	
Indemnity Plan	1-866-316-9776	
Senior Supplement Plan	1-800-851-3802	
(Weekdays 8am – 10pm EST)		
MedicareComplete Plan	1-866-622-8055	
Prescription Solutions	1-800-797-9794 (Avail 24/7)	
ASRS retirees may also call the ASRS On-Site Rep (M-F 8am–5pm MST)		
Phoenix Area	1-602-240-2000	} Press 2
Tucson Area	1-520-239-3100	
Out-of-Area	1-800-621-3778	
		UnitedHealthRX for Groups Medicare Prescription Drug Plan (offered with PacifiCare Senior Supplement) 1-888-556-6648 (Avail 24/7) TTY: 1-877-730-4203 www.unitedhealthrxforgroups.com
		MedicareComplete Prescription Drug Plan 1-866-622-8055, M-F 8am-8pm TTY: 1-888-685-8480
Dental Provider		
Assurant Employee Benefits		www.assurantemployeebenefits.com
Weekdays 7am – 5:30pm CST		
Indemnity Dental Claims	1-800-442-7742	
PPO Dental Providers (DHA)	1-800-985-9895	
Pre-Paid Dental	1-800-443-2995	
Vision Discount Services	1-800-877-7195	www.vsp.com
ASRS retirees may also call the ASRS On-Site Rep (M-F 8am–5pm MST)		
Phoenix Area	1-602-240-2000, ext. 2032	
Tucson Area	1-520-239-3100, ext. 2032	
Out-of-Area	1-800-621-3778, ext. 2032	
Prescription Discount Card		
ScriptSave	1-800-700-3957	www.scriptsav.com
Weekdays 9am – 8pm EST		
Saturday 10am – 3pm EST		
Hearing Benefits		
Arizona HearCare Network	1-800-532-3331 Weekdays 8am–4:30pm MST	www.arizonahearcare.com
ASRS Member Services		
Phoenix Area	1-602-240-2000	www.azasrs.gov
Tucson Area	1-520-239-3100	
Out-of-Area	1-800-621-3778	
TTY Users	1-602-240-5333	
Weekdays 8am – 5pm MST		
PSPRS, CORP and EORP Benefits Office		
Weekdays 8am – 5pm MST	1-602-255-5575	www.psprs.com
ADOA Benefits Office		
Weekdays 8am – 5pm MST	1-602-542-5008	www.benefitoptions.az.gov
	1-800-304-3687	
Other Helpful Numbers and Websites		
Social Security	1-800-772-1213	www.ssa.gov
Medicare	1-800-633-4227	www.medicare.gov

Arizona State Retirement System

Member Services Division

3300 North Central Avenue
Phoenix, AZ 85012

Member Services Division

7660 E. Broadway Blvd., Ste 108
Tucson, AZ 85710